

103
BUDGET ISSUES RELATING TO MEDICARE

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Budget Issues Relating to Medicare, ... **INGS**

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

**Payment Under Part A of the Medicare Program and
Payment for Hospital Outpatient and End-Stage Renal
Disease Services**

MARCH 18, 1993

**Payment Under Part B of the Medicare Program for Phy-
sician Services, Clinical Laboratory Tests, and Durable
Medical Equipment**

MARCH 25, 1993

**Payment Under Part B of the Medicare Program for Clin-
ical Laboratory Services, Durable Medical Equipment,
Physician Ownership and Referral Arrangements, and
Other Medicare Reconciliation Issues**

APRIL 20, 1993

Serial 103-15

Printed for the use of the Committee on Ways and Means



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CONTENTS

PAYMENT UNDER PART A OF THE MEDICARE PROGRAM AND PAYMENT FOR HOSPITAL OUTPATIENT AND END-STAGE RENAL DISEASE SERVICES—MARCH 18, 1993

	Page
Press release of Thursday, March 11, 1993, announcing the hearing	2

WITNESSES

U.S. Department of Health and Human Services, William J. Toby, Jr., Acting Administrator, Health Care Financing Administration	5
Prospective Payment Assessment Commission, Stuart H. Altman, Ph.D., Chairman, and Donald Young, M.D., Executive Director	16

American Association of Kidney Patients, A. Peter Lundin, M.D.	123
American Health Care Association, Bruce Yarwood and Robert Deane	107
American Hospital Association, Rick Pollack and Jim Bentley	40
Association of American Medical Colleges, Spencer Foreman, M.D.	67
California Association of Hospitals and Health Systems, C. Duane Dauner	100
Central Florida Kidney Center, Orlando, Fla., Maureen Michael	114
Greater New York Hospital Association, Kenneth E. Raske	88
Montefiore Medical Center, Bronx, N.Y., Spencer Foreman, M.D.	67
National Association of Public Hospitals, Larry S. Gage	47
National Renal Administrators Association, Maureen Michael and Gwen Gampel	114

SUBMISSIONS FOR THE RECORD

American Nephrology Nurses' Association, statement	129
National Association of Long Term Hospitals, Edward D. Kalman, letter and attachment	131
National Kidney Patients Association, Perry S. Ecksel and Robert D. Rosen, letter	136
National Medical Care, Inc., statement and attachment	138
New York State Council on Graduate Medical Education, Lambert N. King, M.D., statement	144
Renal Physicians Association, statement	148

PAYMENT UNDER PART B OF THE MEDICARE PROGRAM FOR PHYSICIAN SERVICES, CLINICAL LABORATORY TESTS, AND DURABLE MEDICAL EQUIPMENT—MARCH 25, 1993

Press release of Thursday, March 11, 1993, announcing the hearing 152

WITNESSES

U.S. Department of Health and Human Services, William Toby, Jr., Acting Administrator, Health Care Financing Administration 156
Physician Payment Review Commission, Richard V. (Dick) Anderson, Interim Chairman, and Paul Ginsburg, Executive Director 167

American Academy of Family Physicians, John M. Tudor, Jr., M.D 226
American Academy of Ophthalmology, Allan Jensen, M.D 254
American Academy of Orthopaedic Surgeons, Rufus F. Stanley, Jr., M.D 231
American College of Physicians, H. Denman Scott, M.D., F.A.C.P 214
American College of Radiology, K.K. Wallace, M.D., and James Morefield, M.D 270
American College of Surgeons, George E. Block, M.D., F.A.C.S 221
American Medical Association, P. John Seward, M.D., and Bruce Blehart 192
American Society of Anesthesiologists, Peter L. McDermott, M.D 275
American Society of Internal Medicine, Richard D. Ruppert, M.D., and Allan R. Nelson, M.D 245
College of American Pathologists, Donald A. Senhauser, M.D 284

SUBMISSIONS FOR THE RECORD

American Association of Nurse Anesthetists, statement 299
American College of Rheumatology, statement 309
American Physical Therapy Association, statement 313
American Society of Clinical Oncology, statement 316
Association of Freestanding Radiation Oncology Center, Diane S. Millman, statement 319
Continental Medical Systems, Mechanicsburg, Pa., statement 321
Renal Physicians Association, statement 324

PAYMENT UNDER PART B OF THE MEDICARE PROGRAM FOR CLINICAL LABORATORY SERVICES, DURABLE MEDICAL EQUIPMENT, PHYSICIAN OWNERSHIP AND REFERRAL ARRANGEMENTS, AND OTHER MEDICARE RECONCILIATION ISSUES—APRIL 20, 1993

Press releases announcing the hearing 330

WITNESSES

American Association of Bioanalysts, Alvin M. Salton 333
American Association of Continuity of Care, Irene Paige, R.N 398
American Clinical Laboratory Association, Hope S. Foster 341
American Orthotic & Prosthetic Association, John M. Yarbrough, and David Schultz 386
Community Medical Laboratory, Metuchen, N.J., Alvin M. Salton 333
Liken Medicare Center, Pittsburgh, Pa., James W. Liken 378
National Alliance for Infusion Therapy, Alan K. Parver 392
National Association of Medical Equipment Suppliers, James W. Liken, and Corrine Propas Parver 378
Home Care Coalition, Irene Paige, R.N 398
Trautman's Minneapolis Artificial Limb Co., and Rochester Orthopedic Appliances, Minneapolis, Minn., John M. Yarbrough 386

SUBMISSIONS FOR THE RECORD

American Association for Clinical Chemistry, Inc., statement 411
American Association for Clinical Endocrinologists, statement and attachment 413
American Association of Nurse Anesthetists, statement and attachment 416

	Page
American Payroll Association, Carolyn M. Kelley, letter and attachment (forwarded by the Honorable Jim McDermott, a Representative in Congress from the State of Washington)	426
American Society of Clinical Pathologists, Thomas A. Bonfiglio, M.D., statement	429
American Society of Internal Medicine, statement	433
Council of Nursing Home Suppliers, Neal Thrift, statement	435
National Association for the Support of Long Term Care, statement	438

**BUDGET ISSUES RELATING TO PAYMENT
UNDER PART A OF THE MEDICARE PRO-
GRAM AND PAYMENT FOR HOSPITAL OUT-
PATIENT AND END-STAGE RENAL DISEASE
SERVICES**

THURSDAY, MARCH 18, 1993

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, D.C.***

The subcommittee met, pursuant to notice, at 10 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 11, 1993

PRESS RELEASE #6
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
BUDGET ISSUES RELATING TO PAYMENT UNDER
PART A OF THE MEDICARE PROGRAM AND PAYMENT
FOR HOSPITAL OUTPATIENT AND END-STAGE RENAL DISEASE SERVICES

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on budget issues relating to payment to providers under Part A of the Medicare program, and payment for hospital outpatient and end-stage renal disease (ESRD) services.

This hearing will be held on Thursday, March 18, 1993, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

The President's budget proposals would achieve \$48.3 billion in savings under Medicare over a five-year period, according to preliminary estimates by the Congressional Budget Office (CBO). This hearing will focus on proposals that would affect payments to hospitals and nursing homes under Part A, as well as payments for hospital outpatient and ESRD services.

CBO estimates that the President's plan would achieve \$16.1 billion in savings under Part A over the five-year period.

Testimony will be presented by the Prospective Payment Assessment Commission, which is required to report on March 1 of each year regarding the Commission's recommendations on policies concerning payments to hospitals and other facilities under the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, April 2, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing may be submitted in other forms.

Chairman STARK. Good morning. We will begin consideration of issues related to the 1994 budget. Today's hearing will focus on payments for services under Medicare part A. We will also consider Medicare payments for hospital outpatient and end-stage renal disease services.

The subcommittee is scheduled to hold another hearing next week to consider budget matters pertaining to Medicare part B.

Cutting hospital payments as a general rule makes good sense to the Chair. From our previous hearings on the implications of rising health care costs, it is clear that we need drastic action.

I don't know why the taxpayer and Medicare should pay for any part of another new hospital in a State which does not have a health plan in place. In the State of California, the hospitals are 40 percent empty, and they are building new hospitals. This should stop.

The taxpayer should have no part in opening new heart centers in States without a strong health plan. In California, we now have 119 heart centers, with some doing as few as two operations a month.

It seems there should be no more Medicare money for new MRIs and similar devices in States without a plan. The overbuilding of these machines is killing the budget. To paraphrase the movie, "If you build it, they will come"—and then submit the bills to Medicare.

If we want to save big hunks of money, we should take a hard look at tying new capital to health planning and certificates of need.

We should also take a hard look at imposing a national health expenditure budget and Medicare's rate-setting method on all payers. Those proposals would propel us toward our goal of an affordable health care system.

Today's hearing will begin with testimony from William Toby, the Acting Administrator of the Health Care Financing Administration. We will then proceed with testimony presented by Dr. Stuart Altman, Chairman of the Prospective Payment Assessment Commission, affectionately known as ProPAC—that is, the Commission, not Stuart.

ProPAC is required to report on March 1 of each year regarding the Commission's recommendations on policies concerning payments to hospitals and other facilities under the Medicare program.

Before proceeding, I would like to recognize the distinguished ranking minority member, Mr. Bill Thomas, for an opening statement—two opening statements.

Mr. THOMAS. I will leave the other one on the table, Mr. Chairman. Thank you very much.

Now, health care may or may not happen this year, but this committee and the Congress will legislate a reconciliation bill in a matter of weeks. This means the Medicare payment changes proposed by the administration will be seriously considered and at least serve as a starting point for the Health Subcommittee action. So the hearing today, Mr. Chairman, is critically important, in my opinion.

It is vital, as this subcommittee considers Medicare policy in a reconciliation context, that we balance budget requirements with

the need to maintain access to health care for the elderly and disabled. It is also important that Medicare policy changes not contribute to more cost shifting. Medicare cuts which lead to cost shifting may reduce the deficit, but are nothing more than a hidden tax on employers and other private sector payers.

At the same time, Medicare and Medicaid are together primary drivers of a long-term structural deficit. These entitlement programs serve an important role, but their affordability clearly continues to challenge us. The Ways and Means Committee and the Congress over time will have to come to grips and find its own balance between reassuring the elderly and disabled of Medicare benefits, while reducing the drain of that program on the taxpayer. Medicare, I think, is a critical component in the solution of our health care problems.

Possibly health reform may offer an opportunity to begin serious deliberations about this balance of our responsibilities to the beneficiaries and to the taxpayers. Clearly this budget process is not designed to answer this question. If we don't move ahead in health reform to meet the challenge of entitlements, the time is not too distant when we will have to discuss the very structure of the program.

Mr. Chairman, I look forward today to our examination of Medicare part A and hope at least the hearing will enlighten us as to concerns we will have to consider as the subcommittee moves to reduce Medicare spending, once again, by bearing down on hospitals and doctors that provide the service for the beneficiaries. But this is an all too familiar reconciliation pattern among budgets. My concern is that once the President's health care program is announced and we are attempting to make structural reform, are we going to continue to deal with ratcheting down to cover ongoing current costs in budgets in fiscal years 1994, 1995, and 1996? Or are we going to get serious?

Thank you, Mr. Chairman.

Chairman STARK. Thank you. Do any other members care to make a statement?

[No response.]

Chairman STARK. If not, we will begin with testimony from Mr. Toby, the Acting Administrator of HCFA. And as for all witnesses today, their entire statements will be included in the record, and without objection, you would be invited to summarize or expand on your prepared testimony in any way you are comfortable.

Welcome to the committee.

STATEMENT OF WILLIAM J. TOBY, JR., ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. TOBY. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to be here today to discuss the proposals for Medicare part A, hospital outpatient departments, and end-stage renal disease (ESRD) services in the President's fiscal year 1994 budget.

If current spending patterns persist, we estimate in the year 2000 health care expenditures will reach \$1.7 trillion, or 18 percent

of our gross domestic product. This is a price tag that America cannot afford.

Medicare and Medicaid are a large and growing part of the Federal budget. Over half of the projected growth in Federal spending in the next 5 years is due to increased growth in Medicare spending. Any serious attempt to reduce Federal spending must include curbing the rapid growth in Medicare costs.

The proposed Medicare savings I will discuss today represent one component of a downpayment on the Clinton administration's overall program to reform the health care system and to reduce public and private health care costs.

The growth in the Medicare program is so rapid that the Medicare deficit reduction proposal will not cut total spending. Rather, they will decrease the rate of growth in Medicare spending between fiscal years 1994 and 1998 from 14 to 11 percent annually. More specifically, the combined proposed Medicare reductions will yield about \$53.4 billion in savings over the next 5 years.

We believe that these proposals will provide appropriate incentives for efficiency and streamlining and help control costs until the entire health care system is reformed.

I would like to discuss some of our part A proposals. First, we proposed to extend the 10 percent reduction on hospital capital payments past fiscal year 1995. We now discount aggregate payments for hospital inpatient and outpatient capital costs by 10 percent. By making this 10 percent reduction permanent, we will provide the incentive for hospitals to reevaluate their investment plans and purchase only items that are truly needed. We estimate savings over 5 years will be \$1.5 billion.

Second is reducing the average hospital update to market basket minus 1 percentage point in fiscal years 1994 and 1995. From 1989 to 1991, hospital expenditures have risen twice as fast as the rate of general inflation. By maintaining the update at market basket minus 1 percent, we will provide incentives for hospitals to increase their operational efficiency, and we will be consistent with the ProPAC's recommendations of March 1. The administration estimates a 5-year savings of approximately \$7.1 billion.

Third is moving the annual PPS updates to January 1 of each year, starting fiscal year 1994. A savings of \$6 billion over 5 years will be realized if the payment update is delayed 3 months, from October 1 to January 1.

Fourth, phasing in a reduction in the indirect medical education (IME) payment adjustment. This proposal would modestly reduce the IME adjustment and would provide a 2-year period for hospitals to plan for the change. Numerous studies by ProPAC, the GAO, and the HHS inspector general have shown that the current IME adjustment overcompensates teaching hospitals. This proposal would save \$3.5 billion over 5 years.

Fifth, reforming Medicare payments for direct medical education costs. Under this proposal, direct medical education payments would be based on a national average per resident amount. In addition, Medicare would pay proportionately more for primary care residents to provide incentives for hospitals to recruit and train more primary care residents. Projected savings are \$1.7 billion over 5 years.

Next, eliminating the add-on to hospital-based home health agency (HHA) cost limits. The cost limits for hospital-based home health agencies are currently higher than for freestanding home health agencies. Eliminating the adjustment for hospital-based HHAs promotes competition by leveling the playing field for all HHAs, and encourages higher-cost hospital-based HHAs to become more efficient. Projected savings are \$1.1 billion over 5 years.

Lastly, eliminating return on equity payments to proprietary SNFs. Return on equity payments have been eliminated for all other Medicare providers, and this proposal would eliminate these additional payments for proprietary SNFs. This proposal will, again, level the playing field between proprietary and not-for-profit SNFs at a savings of \$730 million over 5 years.

In addition, the following proposals affecting hospital outpatient departments and the end-stage renal disease program:

First, we propose to increase the reduction in hospital outpatient department payments from 94.2 percent of costs to 90 percent of costs and extend the reduction through fiscal year 1998. The administration proposes to extend the current statutory provision that reduces payments to hospital outpatient departments paid on a cost basis. Since outpatient services are one of the fastest growing components of the Medicare program, the extension would attempt to counter this rapid growth. In addition, we propose to increase the reduction to 90 percent of costs beginning in fiscal year 1996. This would be consistent with our proposal to reduce payments for outpatient capital, which is also set at 90 percent of costs. Estimated savings over 5 years is \$2.7 billion.

Second, we propose to reduce payments for EPO to \$10 per 1,000 units of EPO. EPO is a drug used to treat anemia associated with chronic renal failure; Medicare is the major purchaser. Based on reviews by HCFA and the inspector general, we believe that the current rate of \$11 per 1,000 units of EPO is excessive. By reducing the payment, we would bring Medicare's current payment rate closer to the actual cost that facilities incur for EPO. Estimated savings over 5 years are \$210 million.

In conclusion, Mr. Chairman, we must now take steps to significantly reduce the deficit while we develop options for health care reform. If implemented, these proposals will result in more efficient practices by Medicare providers, reductions in the rate of growth in Medicare spending, and reductions in the Federal deficit.

With your cooperation, we can send a message to the industry and to the American public that health care costs can and must be controlled, and the deficit must be reduced, and both must be done without compromising quality of care.

I look forward to working with you on these and related issues. I am happy to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF WILLIAM J. TOBY, Jr.

ACTING ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

It is my pleasure to be here today to discuss the proposals for Medicare Part A, hospital outpatient departments, and end stage renal disease (ESRD) services in the President's fiscal year 1994 budget. As the new Administration moves forward on its plans to revitalize the economy and stimulate growth, it is quite apparent that we must continue our efforts to control the increasing growth of health care and reduce the burdensome deficit.

Under current spending patterns, we estimate that in the year 2000 health care expenditures will reach \$1.7 trillion, an amount equal to 18 percent of our gross domestic product. This is a price tag that America cannot afford.

Medicare and Medicaid are a large and growing part of the federal budget. Over half of the projected growth in federal spending in the next five years is due to increased growth in Medicare spending. Any serious attempt to reduce federal spending must include curbing the rapid growth in Medicare costs.

The proposed Medicare savings I will discuss today represent one component of a down payment on the Clinton Administration's overall program to reform the health care system and to reduce public and private health care costs. These proposals are designed to reduce public sector health care spending and the deficit without making significant programmatic changes to Medicare. Any structural reforms to the overall health care system will be dealt with in the Administration's health care reform package, due later this Spring.

The growth in the Medicare program is so rapid that the Medicare deficit reduction proposals will not cut total spending. Rather, they will decrease the rate of growth in Medicare spending between fiscal years 1994 and 1998 from 14 percent to 11 percent annually. More specifically, the combined proposed Medicare reductions will yield about \$53.4 billion in savings over the next five years.

From fiscal years 94 through 98, hospitals will receive approximately 57 percent of Medicare outlays. Over the same period of time, approximately 43 percent of our proposed Medicare savings will be derived from hospital payments. We believe that these proposals will provide appropriate incentives for efficiency and streamlining and help control costs until the entire health care system is reformed.

The Administration has seven Part A proposals:

- o Extending the ten percent reduction on hospital capital payments past FY 1995. Currently we discount aggregate payments for hospitals' inpatient and outpatient capital costs by ten percent. We believe that the proposed extension of the current ten percent reduction will continue to encourage hospitals to be more prudent in their capital purchase decisions. At this time, hospital occupancy rates average about 65 percent. By making this ten percent reduction permanent, we will provide the incentive for hospitals to reevaluate their expansion and equipment purchases and purchase only items that are truly needed. Estimated savings over five years will be \$1.5 billion.
- o Reducing the average hospital update to market basket minus one percentage point in fiscal years 1994 and 1995. Current statutes mandating hospital updates less than the market basket rate of increase expire for fiscal year 1994. From 1989-1991, hospital expenditures have risen twice as fast as the rate of general inflation. By maintaining the update at market basket minus one percent, we will continue to provide incentives for hospitals to increase their operational efficiency. This proposal is also generally consistent with the Prospective Payment Assessment Commission's March 1

recommendations. The Administration estimates a five year savings of approximately \$7.1 billion.

- o **Moving the annual hospital updates to January 1 of each year, starting fiscal year 1994.** A savings of \$6 billion over five years will be realized if the payment update is delayed three months, from October 1 to January 1. This proposal would establish uniform starting dates for payment updates for most providers. In addition, this proposal provides a stable planning environment for hospitals and fiscal intermediaries which, in the past, have experienced unexpected changes in their payments when the budget reconciliation process has extended beyond the start of the new fiscal year.
- o **Phasing-in a reduction in the indirect medical payment adjustment.** Currently, Medicare pays hospitals for its share of the indirect medical education (IME) costs associated with the training of interns and residents. This proposal would modestly reduce the IME adjustment and would provide a two-year period for hospitals to plan for the change. There have been numerous studies conducted by the Prospective Payment Assessment Commission, the General Accounting Office, and the HHS Inspector General that have shown that the current IME adjustment overcompensates teaching hospitals for the additional indirect costs resulting from the presence of interns and residents. By implementing this proposal, we would save \$3.5 billion over five years.
- o **Reforming Medicare payments for direct medical education costs.** Currently, Medicare payments are based on each hospital's per resident costs. Under this proposal, direct medical education payments would be based on a national average per resident amount. In addition, Medicare would pay proportionately more for primary care residents. Using national averages will correct some of the current payment inequities in direct medical education payments. The proposed changes will also provide incentives for hospitals to recruit and train more primary care residents. Medicare would realize savings of about \$1.7 billion over five years.
- o **Eliminating the add-on to hospital-based home health agency (HHA) cost limits.** The cost limits for hospital-based HHAs are currently higher than for free-standing HHAs. Currently, half of all hospital-based HHAs do not exceed the cost limits set for free-standing HHAs demonstrating that the remaining hospital-based HHAs can meet the lower cost limits of free-standing HHAs. Eliminating the adjustment promotes competition between free-standing and hospital-based HHAs by leveling the playing field for all HHAs. This would encourage higher-cost hospital-based HHAs to become more efficient. Projected savings are \$1.1 billion over five years. And lastly,
- o **Eliminating return on equity payments to proprietary skilled nursing facilities.** Return on equity payments have been eliminated for all other Medicare providers, and this proposal would eliminate these payments for proprietary nursing facilities. By eliminating special treatment for this category of Medicare providers and equalizing payments for both proprietary and not-for-profit skilled nursing facilities, we will promote fair competition between all skilled nursing facilities at a savings of \$730 million over five years.

In addition, we have the following proposals affecting hospital outpatient departments and the end-stage renal disease program:

- o **Increasing the reduction in hospital outpatient department payments from 94.2 percent of costs to 90 percent of costs and permanently extending the reduction, which expires after FY**

1995. The Administration proposes to extend the current statutory provision that reduces payments for those hospital outpatient services paid on a cost basis. This reduction is now 5.8 percent. Since outpatient services is one of the fastest growing components of the Medicare program, the extension would attempt to counter this rapid growth. Without extending the reduction past FY 1995, we fear that outpatient growth would continue to increase at an extraordinarily high rate without any control mechanism to keep spending in check.

In addition, we propose to increase the reduction to 90 percent of costs beginning in FY 1996. This would be consistent with our proposal to reduce payments for outpatient capital, which is also set at 90 percent of costs. Estimated savings over five years is \$2.7 billion.

- o **Setting EPO payments at \$10 per 1,000 units of EPO.** Currently, Medicare pays \$11 per 1,000 units for EPO, also referred to as epoetin, which is a drug used to treat anemia associated with chronic renal failure. This proposal would reduce the amount to \$10 per 1,000 units. EPO is unique in that only one pharmaceutical company manufactures EPO, and Medicare currently purchases 90 percent of EPO. Based on studies conducted by the Inspector General and on our reviews, we believe that the current rate of \$11 per 1,000 units of EPO is excessive. By reducing the payment to \$10 per 1,000 units of EPO, we would virtually eliminate the disparity between Medicare's current payment rate and the actual cost that facilities incur for EPO. Estimated savings over five years are \$210 million.
- o **Extending the provision requiring secondary payment for certain beneficiaries with end stage renal disease.** Under current law, Medicare makes a secondary, rather than primary payment for beneficiaries with end stage renal disease (ESRD) who have health coverage through a group health plan. Medicare makes these secondary payments for the first 18 months of entitlement. After the 18 month period, Medicare makes primary payment. This provision is due to revert to a 12 month period beginning in 1996. We propose to make the 18 month time period permanent. Estimated savings are \$105 million over five years. And finally,
- o **Providing reform to Medicare Secondary Payor (MSP) provisions.** One component of the Administration's proposal is to make the small employer threshold consistent for all of the various MSP provisions for the elderly, disabled and those with ESRD. The proposal would establish the threshold at employers of twenty or more persons, which is the current threshold for the working aged. All components of this proposal yield savings over five years of \$3.9 billion. However, the change relating to ESRD beneficiaries would increase costs modestly, since very small employers would be relieved of the burden of paying primary coverage to Medicare for employees with ESRD.

The proposals discussed represent the Administration's recommendations for reducing the rate of growth in Medicare Parts A and B spending in hospitals and for ESRD services. I will be presenting the Part B proposals for reduced Medicare spending for physician and lab services and DME suppliers to the Subcommittee next week.

We must now take steps to significantly reduce the deficit while we develop options for health care reform. If implemented, these proposals will result in more efficient practices by Medicare providers, reductions in the rate of growth in Medicare spending, and reductions in the Federal deficit. By targeting inefficiencies in the health care market and promoting more cost effective practices by Medicare providers, we would enhance efficiency without compromising the quality of the services

rendered.

These changes can contribute to providing the stimulus necessary for the health care industry to determine and implement ways to contain health care costs while also contributing to deficit reduction. And it is vital that the Federal government take a leadership role in signaling to the health care industry that high quality, efficient health care services can and must be provided.

With your cooperation, we can send a message to the industry and to the American public that health care costs can and must be controlled, and the deficit must be reduced, and both must be done without compromising quality of care.

I look forward to working with you on these and related issues. I am happy to answer any questions you may have.

Chairman STARK. Thank you. Mr. Toby, I have just a couple of quick questions. Your market basket reduction of 1 point—that is different from what we will be hearing from ProPAC, is it not?

Mr. TOBY. Mr. Chairman, it is quite close to ProPAC's recommendation.

Chairman STARK. That is? That is ProPAC's recommendation, is it?

Mr. TOBY. ProPAC recommended a 3.6 percent increase. Our proposal reflects a 3.5 percent increase.

Chairman STARK. OK. There was a postponement of 30 days, 90 days—I am looking for it in your testimony—to move the updates to January starting in 1994, and we get \$6 billion over 5 years. That is a one-time pickup in cash; is that correct?

Mr. TOBY. That is correct.

Chairman STARK. Thank you.

Mr. Thomas.

Mr. THOMAS. Mr. Toby, this may be unfair, but I am new to this subcommittee. How many years have you been in HCFA?

Mr. TOBY. Since its creation, sir, in 1977.

Mr. THOMAS. And it is fair to say you have come up through the ranks in a way? I mean, you have seen it in a number of different dimensions. You weren't just brought in at the top and had to look down.

Mr. TOBY. No, sir. I have been in the Department of Health and Human Services since 1968.

Mr. THOMAS. So you have looked up a lot? You have looked up as well as looked down?

Mr. TOBY. That is correct.

Mr. THOMAS. These lights go off fairly quickly. Can you in a relatively short time—and I don't want to say three things, but one, two, or three things, or you can submit a list of a dozen. But given your experience inside HCFA, you know well the agitation and concerns that folk have in terms of the way the place operates. It is a bureaucracy. But if you could make some changes now, what are the two or three things—and I said I wasn't going to do that—that we can focus on that would make the most difference as far as you are concerned? Or are there just hundreds of items that have to be done to make a difference?

Mr. TOBY. Within HCFA?

Mr. THOMAS. Yes, inside HCFA.

Mr. TOBY. Well, I came to HCFA as Acting Administrator, as you probably know, about a year ago, and having been in the organization since its inception, one of the things I was very much aware of was the incredibly difficult task that HCFA has in terms of developing policy on financing, quality, and other important issues. I felt very strongly that there are a number of things that could be done to regulate the industry as well as develop policy. The first step is to recognize that our beneficiaries and providers are our very best customers. This concept was not recognized inside of HCFA. It took me several months to develop for HCFA a total quality management (TQM) initiative. I think TQM offers incredible promise of improving relations with the world outside of HCFA in terms of making our agency employees very much aware of the incredible power that they have over the health care industry.

I think most HCFA employees, who are a superb cadre of people, have in the past not recognized the full impact of HCFA's policies on our providers and the whole industry. I have been working very hard within HCFA to turn the staff around to make sure that we are aware of the impact of our policies on providers and others. And most importantly, that we need to treat our beneficiaries and providers as our best customers. And I think we are doing a good job of that.

We also are preserving a number of internal management reforms inside of HCFA, recognizing that we have been the object of some criticism by organizations such as the GAO, which believes that there is a lot of waste and fraud that we are not on top of. We have worked to improve our Medicare contractors program by gaining greater uniformity and accountability of payment by insurers.

One of the internal reforms we have is our Medicare transaction system which will improve claims processing. I think we are currently doing a fairly good job of paying our providers on time, but there is always room for improvement.

We are also reforming the peer review organization program. As you know, many physicians have felt that most of our activities are to investigate and punish. We are trying to turn this perception around by working with the physician community. We are reforming the peer review organizations to move away from the case-by-case "seek and punish" approach to one of basically looking at the outcomes so we can make a decision as to whether or not a beneficiary is receiving the proper treatment and receives a positive outcome from the physician's care. This new approach should not halt most of the criticism we have received from physicians on our past approach.

Over the last several months HCFA has received numerous accolades from the American Medical Association and the American Hospital Association for efforts we have taken to reduce the hassle factor. Most of the success is due to HCFA utilizing the TQM deliberations to become more aware of new actions that could be taken, such as intermediate steps, that wouldn't have the negative effects of past efforts that have been implemented in various regulations and laws.

In addition, we have the Advisory Panel of Practicing Physicians. We invited the panel in to work with us to identify items that physicians felt were very troublesome, and were considered to be an impediment to their practice of medicine and at the same time didn't improve the operation of the Medicare program. The panel has given HCFA many ideas about reforms that could be developed. Currently, we are implementing these specific reforms to improve our regulations and overall procedures.

So I think HCFA has improved its perception of how to best serve our most important customers, Medicare beneficiaries and their providers, over the past year. I think that HCFA is a better organization because of the improvements I have recommended and successfully implemented.

Mr. THOMAS. Well, yes, if you brought a sense of the outside world and their concepts, you had a heavy burden to bear. And I

am all for total quality management. Some folks would settle for some quality management.

The biggest complaint I continue to get and deal with as someone who has to be an interface, an ombudsman, if you will, with Government, is the really unfair role of Government in terms of requiring mandates, monitoring, and an enormous amount of book-keeping on people, and then simply being unwilling to pay people on a timely basis for what are fair rendered services. If you really wanted to make a big hit out there, that alone, I think—pick a number, 30 days, 45 days, any kind of a fixed turnaround that is required on the private sector on an ongoing basis—would be a wonderful advancement. But I wish you well.

Thank you very much, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, and a warm welcome.

Clearly, there has to be a major reduction in the inflation of health care costs, and Medicare clearly has to bear a good part of the burden, a fair part. I think this administration is determined to have these reductions driven by policy and not be willy-nilly.

Mr. Toby, let me, if I might, ask you just a few questions in that regard, and I realize that it may not really be possible to give very final answers because some of the proposals are not yet complete. But I think these are some of the standards that we must look at.

For example, you say in your testimony that hospital occupancy rates average about 65 percent. I think we have to ask ourselves how these cuts relate to hospital occupancy. Is there any relationship?

Secondly, some hospitals carry much more burden than others in terms of uncompensated care and other types of care. So a second question, I think, is: Is there any relationship, or what is the relationship between these budget cuts and hospitals that are carrying a special burden? That is the second one; the first is occupancy.

Then I would think a third one is the standard of profitability which will relate to the first two; that is, is there any relationship between the proposed budget cuts and the profitability of various types of hospitals?

I think, for example, the proposal on direct medical education must be looked at in terms of these three and perhaps other standards, going over to a national average.

So let me ask you, at this point are you in a position—is HCFA in a position—to discuss the relationships between the proposed cuts in these three standards and any other ones that might be relevant?

Mr. TOBY. Well, in regard to your question about standards, sir, occupancy is one indication that hospitals, in general, are underutilized. In addition, we look at a number of other areas to determine our update payments. When we decide on taking a policy approach, for the most part, we are always concerned about the financial health of institutions and hospitals. We know in particular many inner-city hospitals and teaching hospitals carry an added burden of treating many of the uninsured.

We also are very concerned as to whether or not the payment policy implemented will have an adverse effect on access for Medicare beneficiaries. We have approximately 36 million Medicare

beneficiaries to serve and Medicare must continue to provide accessible and affordable health care. Medicare had been the leader in terms of controlling health care spending and certain costs for health care beneficiaries by giving incentives to providers to provide care in an efficient manner. So these are some of the standards HCFA uses to provide quality care at an affordable price.

In response to your question on profitability, we think that hospitals can provide high quality services to beneficiaries in an effective and efficient manner. Medicare pays a price prospectively up front for a specific service, and we assume that hospitals will have the kind of efficiencies that will allow them to be profitable.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Toby, welcome. I am pleased to see that your recommendation concerning direct medical education costs, that the primary purpose for that recommendation is to try to increase the training of people in primary care. As we go through this difficult task of reconciliation and trying to deal with the Medicare numbers that we must meet by the budget resolution, I hope we will try to accomplish training more people in primary health care. That is one of the major problems that we are having and that we are looking at in the health care reform bill.

So I personally would appreciate your keeping us informed as we go through reconciliation on what we can do as we look to changing the current Medicare rules to encourage hospitals and medical schools to train more people for primary health care.

Mr. TOBY. Yes, we certainly will.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. No questions.

Chairman STARK. Mr. Toby, thank you very much.

Mr. TOBY. Thank you very much, Mr. Chairman.

[A question from Representative Grandy for Mr. Toby and his response follows:]

Question. Mr. Toby, please specify the impact of the administration's proposal on the elimination of the urban/rural differential for PPS standardized amounts.

Answer. Our proposal will continue current policy in this regard. The proposal will apply update factors to the rural standardized amounts that will be greater than the urban updates for fiscal years 1994 and 1995. This means that beginning in fiscal year 1995 the rural and "other urban" standardized amounts will be the same. Large urban areas (population of 1 million+) will retain a higher standardized amount.

Chairman STARK. We will continue with testimony now from Stuart Altman, Chairman of the Prospective Payment Assessment Commission. Dr. Altman is accompanied by Donald Young, the Executive Director of ProPAC. We welcome you both back to the subcommittee and look forward to your testimony. Your entire statement will be included in the record.

I just wanted to advise the members of the subcommittee, in case they have an interest in this as the testimony develops this morning, that Stuart Altman a few years ago directed the Council on Wage and Price Stability. There has been some discussion that we might have price freezes or price controls, and we have with us today an expert who could run either system.

Mr. THOMAS. Or who could tell us why we shouldn't.

Chairman STARK. Or, indeed, could tell us why we shouldn't. So not only will we look forward to your testimony as to what we should do to slow the rate of inflation of medical care costs, but we may have many other questions for you that will help us as we go along.

Why don't you proceed in any manner that you are comfortable. Welcome back.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DONALD YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. ALTMAN. Thank you, Mr. Chairman.

First I would like to thank you, Mr. Chairman, and the committee for supporting my continuation as Chairman. I was pleased to have been appointed for my fourth term as Chairman, and what is a special privilege is the ability to come up and testify with Don Young at my side. It makes what could be a nervous experience very pleasant.

This, as you know well, is the ninth time that we have come before this committee to provide you with the benefits of our deliberations during the year, and for those of you who are new to the committee, you know that the Commission's responsibility has changed significantly over the last 10 years or so. Originally, we were focused almost entirely on the DRG system and technical changes relating to it. More recently, the Congress has expanded our responsibilities to include outpatient hospital services, skilled nursing facilities, home health services, and most recently to focus on end-stage renal dialysis.

In addition, we have been asked by you and other committees in the Congress to focus more broadly on the issues of health care reform.

In our March 1 report which we submitted, we make several recommendations concerning what we believe should be the appropriate increases in hospital payments by Medicare as well as payments to other facilities, including end-stage renal disease. And I would like to briefly highlight these in a minute. But first let me focus just for 2 seconds on this broader issue of rising spending for health care.

If you take a view about Medicare itself, it is fairly clear that the Medicare program has successfully controlled its spending for inpatient hospital care. The rate of increase in Medicare inpatient hospital spending, which was growing at an annual rate, after adjusting for inflation, of 9.1 percent before PPS, has now slowed to 2.5 percent in the 6 years that PPS has been in existence.

But although Medicare has been able to slow its hospital payment rate, hospital costs have continued to rise rapidly. As Congressman Thomas indicated, most hospitals have been able to offset the difference between Medicare payments and costs and maintain their operating profit margins by raising charges to other payers.

This is an area that, while it doesn't necessarily argue that Medicare should cut back on its vigil, does suggest that all of us in the Federal Government need to recognize that we have to be concerned about how large a differential should be maintained be-

tween Medicare payments and those of private payers, and the implications that Medicare payment policy has on the broader health care system.

Nevertheless, Medicare must maintain its vigil with respect to controlling its spending or face the possibility of serious financial problems for the Medicare program itself.

Now I would like to focus briefly on our recommendations for next year. Even though the law currently in existence implies that Medicare payments to hospitals should go up by the market basket, you have asked us to use our methodology to suggest what should be the increase. And based on our methodology, which we have used now for 9 years, we would recommend that average payments to hospitals increase by about 3.6 percent, which is composed of a 3.4 percent increase for urban hospitals and a 4.9 percent increase for rural hospitals.

In addition, we have recommended that the Federal portion of the capital payment rate go up by 2.7 percent for both urban and rural hospitals.

In addition, we have recommended that the hospital-specific base year costs for sole community hospitals increase by 4.9 percent, and that for facilities which are excluded from PPS—psychiatric, rehabilitation hospitals, distinct part units, as well as long-term care, children's, and cancer hospitals—increase by 3.2 percent.

Finally, we make our first recommendation with respect to the update factor for dialysis services, which have not increased for many years, and our recommended increase for these services is 2.5 percent.

I want to focus the committee's attention a bit, though, not on the increase, but on an issue of fairness. As the gap has widened between what Medicare pays and what hospital costs are, I think we all need to be more concerned than ever that the system that we develop is fair to all hospitals. In that context, we have focused on several components of the PPS system which we believe are very important.

First is the wage index. Roughly \$35 billion of PPS payments are distributed to hospitals throughout the United States based on adjustments in that wage index. Every analysis of that wage index suggests that it is terribly unfair. You have tried to fix it several times. You have introduced all kinds of adjustments, the latest of which is the creation of a Medicare geographic classification review board. And while you have tried and we have tried mightily, I have to say it has been a colossal mess.

We have tried, with the help of people on your committee as well as the help of people in HCFA, to develop a new index, and we think we are on the verge of having created one that might work better. It basically builds on a hospital's own specific labor market costs and looks at the labor costs of hospitals in its surrounding area. Based on our analysis, which has been going on now for several years, we think this method is substantially better than the method that is currently in existence, and we hope to work with your committee as well as HCFA on developing this method so that it could be introduced as legislation shortly.

A second area is outlier payments. Outlier payments is a very technical issue, and often in this committee we don't talk about it.

But it has a tremendous impact on those hospitals that treat our sickest patients, and it really needs to be adjusted.

I won't go through the adjustments now, but I would urge you and members of your staff to work with us to make the kind of adjustments we suggest. We need to change the way we focus on outliers from what used to be called a day outlier policy to a cost outlier policy. We need to change the way outliers are calculated. And we have a whole series of recommendations. I hope you and HCFA and other Members of the Congress will focus on this issue because it really gets to the heart of fairness.

Finally, we need to focus on the issue of the indirect medical education. As Mr. Toby indicated, we have been looking at this for a long time, and we realize and support the need for teaching hospitals to receive extra payments. They are, after all, the institutions that provide us with our new physicians, and they also provide extra care to our low-income and disadvantaged populations. They are also our institutions that we look to often when we are the sickest.

But we also have to bear in mind that we have a duty not only to those institutions, but to all hospitals, and we have tried to come up with the best index of doing that. Our recommendation is that we reduce somewhat the teaching adjustment which currently is at a rate of 7.7 percent to a rate which is close to 7 percent.

But we caution you and the administration that when we reduce the indirect medical education adjustment, we do it very gingerly because we are, after all, impacting on institutions that are as important as any we have in our health system.

We also have several recommendations with respect to transfer policies. Again, I would suggest that we work with your committee on that.

Finally, in my testimony I focus on recommendations and spending for other settings, but I will just ask that my full testimony be in the record and that we have the opportunity to talk with your committee.

Again, it is a privilege and a pleasure for me to be here this morning, and I look forward to working with your committee for the years ahead. Thank you very much, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY FOR THE
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION
STUART H. ALTMAN, PH.D., CHAIRMAN

Good morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission. With me today is Dr. Donald Young, the Commission's Executive Director. I am pleased to be here this morning to describe ProPAC's work and to present our most recent recommendations to the Congress and the Secretary of Health and Human Services for updating and improving Medicare payment policies for hospitals and other facilities.

COMMISSION RESPONSIBILITIES

Because the Subcommittee has a number of new members, Mr. Chairman, I first would like to review briefly the Commission's role and responsibilities. ProPAC is an independent Congressional agency that was established in the 1983 legislation that created the Medicare prospective payment system (PPS) for inpatient hospital services. Our work is heavily influenced by Congressional needs and requests for studies and reports.

When we first appeared before this Subcommittee almost ten years ago, our primary responsibilities were updating and improving the Medicare prospective payment system. Since then, Congress has greatly expanded our mandate, and we now also are responsible for providing analyses and recommendations to Congress concerning Medicare policies for excluded facilities, outpatient hospital services, skilled nursing facility and home health services, and end-stage renal disease dialysis services. We also now have responsibilities related to Medicaid hospital payment and the analysis of issues related to health care reform.

Last year we submitted a report, requested by this Committee, describing the steps necessary to implement an optional payment system for private payers based on Medicare's methods. In that report, we also described the significant savings that could result from such a system. Currently, we are preparing a report, that we will deliver to you by July 1, 1993, on the design and implementation of a global budgeting system.

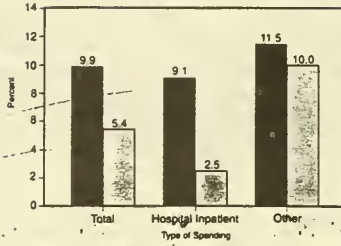
On March 1, 1993, we submitted our ninth annual report to Congress containing recommendations for Medicare program improvements. In that report we also describe the relentless growth in this nation's health care spending and the role the Medicare program has played in attempting to constrain that growth. I would like to briefly highlight some of our findings.

GROWTH IN HEALTH CARE SPENDING

As the members of this Subcommittee know, spending for health care in this nation is projected to grow to \$1.7 trillion by the year 2000, if current trends continue. The level of health care spending, as well as the continued increase in that spending, far exceeds that of any other nation.

Despite the continued rise in total health care expenditures, the Medicare program has successfully controlled its spending for inpatient hospital care. As you can see in Figure 1, PPS had a major effect. The rate of increase in Medicare inpatient hospital spending slowed dramatically with the implementation of PPS. During the six years before prospective payment, Medicare payments grew at a real annual rate--that is, adjusted for general inflation--of 9.1 percent. This rate fell to 2.5 percent over the first six years of PPS.

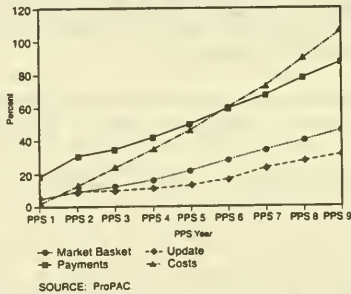
Figure 1. Real Rate of Increase in Medicare Benefit Payments, Before and After PPS (In Percent)



SOURCE: Health Care Financing Administration, Office of the Actuary.

Although the growth of Medicare hospital payments has slowed, hospital costs have continued to rise rapidly. Hospital operating costs per Medicare discharge increased 106 percent in the first nine years of PPS (see Figure 2). This was considerably greater than the 87 percent growth in PPS payments per discharge, and more than twice the 46 percent increase in the hospital market basket index, which reflects the prices of goods and services used by hospitals.

Figure 2. Cumulative Increases in PPS Market Basket, Update, Payments, and Costs, First Nine Years of PPS (In Percent)



SOURCE: ProPAC.

Most hospitals have been able to offset the difference between Medicare payments and costs and maintain their operating profit margins by raising charges to other payers. However, there is considerable variation among hospitals in their ability to generate extra revenues from private payers, and hospitals with a small number of privately insured patients are especially at risk. PPS has provided some assistance to these hospitals through the disproportionate share, teaching, and sole community hospital policies. In 1990, while total hospital payments from Medicare were 10 percent (\$8.2 billion) below costs, payments from private insurers were 28 percent (\$22.5 billion) greater than the cost of treating their patients.

Despite the continuing increase in hospital costs and higher charges to private insurers, the Commission believes that the Medicare program should continue to limit the growth of inpatient hospital payments. To do otherwise would threaten the financial viability of the Medicare program and encourage further hospital cost inflation. But the Federal government should also recognize that there are limits to how large the differential between its payments and those of private payers can be, and it must recognize the implications of what it does on the broader health care system.

UPDATE FACTOR RECOMMENDATIONS FOR FISCAL YEAR 1994

PPS Operating Update

As you know, Mr. Chairman, the 1994 update for inpatient hospital operating costs has been set by law. Nevertheless, as requested by Congress, the Commission followed its past approach of examining individual factors that together determine its update recommendations. Based on that methodology, ProPAC recommends an average payment update of 3.6 percent for PPS inpatient hospital care for fiscal year 1994. Urban hospitals should receive a per case payment increase of 3.4 percent and rural hospitals should receive a 4.9 percent increase.

While ProPAC's update recommendations are lower than the updates set by law, we believe our recommendations are appropriate and sufficient to maintain Medicare enrollees' access to quality care, while encouraging hospital efficiency in providing that care. I also should note that the annual growth in average payments per case is actually greater than the PPS update. This is due to the fact that changes in the mix of cases hospitals treat, as measured by the case-mix index, are estimated to increase payments by 1.9 percent in fiscal year 1994. As a result, the actual average increase in per case payments (using our update recommendation) would be about 5.5 percent.

Capital Update

This year the Commission also is recommending an update for the Federal capital payment rate. In 1992, Medicare's payment method for hospital capital expenses was changed from a cost basis to a prospective per case basis. This new payment method is being phased in over a ten year period. During this transition, an increasing portion of capital payments will be based on the Federal capital payment rate. We believe that the Federal rate should be increased using a formula that is similar to that used to update PPS operating payments. Using this approach, we recommend a fiscal year 1994 update of 2.7 percent for both urban and rural hospitals. We also believe that, ultimately, there should be a single update for both operating and capital payments. If a fully phased-in capital prospective payment system were in place in fiscal year 1994, the recommended combined update would be 3.5 percent. Increases in the case-mix index, however, would actually increase total payments about 5.5 percent.

Other Updates

Mr. Chairman, pursuant to our mandate, we also are recommending the following updates for fiscal year 1994. For rates derived from hospital-specific base-year costs, for sole community hospitals, we recommend an update of 4.9 percent. This increase is the same as the PPS update for rural hospitals. For facilities that are excluded from PPS (psychiatric and rehabilitation hospitals and distinct part units as well as long-term, children's, and cancer hospitals) we recommend that payments increase by 3.2 percent. Finally, we recommend that the composite rate payment for dialysis services should be updated by 2.5 percent. A summary of our update recommendations is shown in Table 1.

Table 1. ProPAC Recommended Update Factors, Fiscal Year 1994

Overall PPS hospital operating payments	3.6%
Large urban areas	3.4
Other urban areas	3.4
Rural areas	4.9
Total capital update	2.7
Hospital-specific rates	4.9
PPS-excluded hospitals	3.2
Dialysis services composite rate	2.5

EQUITY IN DISTRIBUTION OF MEDICARE PAYMENTS

Mr. Chairman, I now would like to turn to the issue of equity in the distribution of Medicare payments. As the gap between Medicare payments and costs widens, we believe it is even more important that Medicare policies continue to be refined to ensure that the payment system is fair to all hospitals. As part of our mandate, ProPAC monitors the distribution of PPS payments across hospitals and makes recommendations concerning adjustments to those payments. Our March Report identifies a number of areas where we believe policy improvements are necessary. I would like to highlight several of our recommendations.

PPS Wage Index

The PPS wage index is used to adjust hospital payments to reflect geographic differences in the price of labor hospitals must purchase to provide inpatient services. Currently, the wage index directly affects the distribution of more than \$35 billion in PPS payments. Consequently, the accuracy of the wage index is a key component of payment equity among hospitals.

The current method for determining the hospital wage index has proven to be unfair to many hospitals, urban and rural alike. For example, the metropolitan statistical areas (MSA) used to determine the labor market areas have arbitrary boundaries that do not accurately reflect the labor market conditions hospitals face. The new MSAs that were recently released exacerbate this problem.

Congress attempted to alleviate the inequities associated with labor market areas by creating the Medicare Geographic Classification Review Board. The Board reviews and approves applications from hospitals to be reclassified into different labor market areas for the purpose of the wage index. Our research shows, however, that geographic reclassification has not been an effective solution.

In response to requests from Congress, ProPAC has developed and evaluated a new method for determining hospital labor market areas that will reduce many of the problems associated with the current wage index. Our approach uses hospital-specific labor market definitions based on hospital geographic proximity. We believe that hospital-specific labor market areas will substantially improve the accuracy and integrity of the PPS wage index. Under this method, individual labor market areas would be defined for each hospital to include only those hospitals in the immediate vicinity. In the next month, ProPAC will release a Technical Report Series document that will provide a complete description and analysis of this new approach.

Outlier Policy

The Commission also is recommending improvements in the PPS outlier policy. The current outlier policy gives hospitals additional payments for cases that have exceptionally long stays or exceptionally high costs. Initially, outliers based on length of stay ("day outliers") have received the greater portion of the outlier pool. Our research has shown, however, that while day outliers generally are more expensive than the average case, they frequently are not associated with large financial losses to the hospital. In contrast, cost outlier cases are associated with even larger losses to the hospital. Accordingly, over time, the Secretary has decreased the emphasis of day outliers.

The Commission supports the increased emphasis on cost outliers relative to day outliers because we believe costs more effectively identify the cases associated with the largest losses to the hospital. We recommend that the proportion of day outlier payments be reduced to 23 percent in fiscal year 1994, 12 percent in 1995 and zero in 1996. ProPAC will continue to monitor and analyze this issue to ensure that distribution of outlier payments is fair and appropriate.

Under the outlier policy, a case does not qualify for additional payment unless it exceeds a certain threshold. We believe that the threshold should be changed so that it is based on a fixed dollar loss above each DRG payment. Also, currently, hospitals receive outlier payments of 75 percent of the estimated costs beyond the cost threshold level. We believe this percentage should be raised to 80 percent.

In addition, the pool of money used to finance outlier payments is obtained by setting aside a portion of total PPS payments. Under current law, the percentage set-aside must be between 5.0 and 6.0 percent; currently it is 5.1 percent. We believe that an outlier payment pool of 6.0 percent is most appropriate at this time because it would reduce the losses for hospitals that treat a large number of outlier cases.

Indirect Medical Education (IME) Payments

We also have continued our analysis of payments to teaching hospitals. Under PPS, payments to teaching hospitals are adjusted to recognize the higher costs these hospitals incur in treating Medicare patients. Every year, ProPAC estimates the relationship between teaching intensity and costs per discharge. Our most recent analysis indicates that, on average, a 10 percent difference in teaching intensity is associated with a 5.4 percent difference in Medicare operating costs per discharge. Our analyses also show that PPS margins for teaching hospitals have been consistently higher than for non-teaching hospitals, although their total margins continue to be somewhat lower.

Based on our findings, we believe that a reduction in the IME adjustment is warranted. We recommend that the IME payment adjustment be reduced from 7.7 percent to 7.0 percent. A gradual reduction is appropriate because a sharp reduction in IME payments might adversely affect access to quality health care for Medicare beneficiaries. We also recommend that the savings from this reduction should be returned to all hospitals through a proportionate increase in the PPS standardized payment amounts.

Transfer Policy

Over the last several years, ProPAC has conducted an extensive analysis of Medicare's transfer payment policy. That analysis shows, Mr. Chairman, that the current policy undercompensates the treatment costs incurred by the transferring hospital. This is because the payment approach does not recognize the frequently higher costs of evaluating and stabilizing patients early in their hospital stay.

Accordingly, we recommend that Congress provide authority to the Secretary to implement a per diem payment for transfer cases that reflects this pattern.

MEDICARE SPENDING IN OTHER SETTINGS

Mr. Chairman, I now would like to address the issue of Medicare spending in settings outside of the hospital. Although the growth in Medicare spending for inpatient hospital care has slowed, Medicare expenditures for services furnished in other settings has continued to increase 10 percent a year above the rate of inflation (see Figure 1). Health care spending can increase because the price of services increases or the volume of services increases. The Medicare program generally has been successful in controlling the price of specific services. Experience shows, however, that costs continue to grow because the volume of services has increased. We are very concerned about the continued growth in the volume of services. Efforts to constrain volume, however, are hampered by the large number of different sites and providers of care, and lack of information concerning the appropriateness and value of much of the care that is furnished.

I briefly would like to summarize several of our recommendations to improve the effectiveness and equity of Medicare payments for services furnished in other settings.

Outpatient Services

The Commission continues to be concerned about the overall growth in spending for hospital outpatient services. The Commission supports Congress' intent to establish prospective payment methods for hospital outpatient services. The Commission has been studying this area and has submitted two background reports. We support the research the Secretary has undertaken to develop a classification system for ambulatory services. As mandated by OBRA 1990, we will review and comment upon the Secretary's proposal when it is released.

Mr. Chairman, in our March Report we repeat an important recommendation concerning beneficiary liability under the current method of paying for outpatient services. Medicare payment for most hospital outpatient services is at least partly based on costs or charges, whichever is less. Because payment is not determined until the hospital submits its annual Medicare Cost Report, beneficiary liability is set at 20 percent of the hospital's charges, rather than 20 percent of payments, as it is in other settings. Because hospital charges for outpatient services generally are higher than costs or payments, Medicare patients end up paying substantially more than 20 percent of costs or payments. The Health Care Financing Administration (HCFA) estimated that in 1992, 40 percent of hospital payments for ambulatory surgical services were paid by beneficiaries; for radiology services beneficiary liability was 50 percent of payments.

Mr. Chairman, this payment policy unfairly penalizes beneficiaries who receive care in hospital outpatient settings. Accordingly, we believe that a Medicare beneficiary's liability should be based on 20 percent of the payment allowed by Medicare. Until prospective payment is implemented for outpatient services, this amount should be 20 percent of Medicare-allowable costs, which can be estimated from available information.

Other Settings

Medicare expenditures for other facilities that are not paid prospectively have also escalated. These facilities include nursing facilities, home health agencies, and PPS-excluded hospitals and distinct-part units. The Congress has directed the Secretary and ProPAC to look at potential prospective payment methods for these facilities. The Secretary has been directed to develop specific payment proposals, and

we have been directed to analyze and comment on those proposals. The Secretary has not yet submitted her proposals; however, we have released interim background reports describing each of these facility types. We will continue to monitor these areas and will analyze and comment upon the Secretary's proposals when they are released.

Quality of Care

Ensuring quality care for beneficiaries is an important responsibility of the Medicare program. We believe the Medicare program must continue to strengthen its quality assurance programs and oversight mechanisms, especially in settings outside of the hospital. Presently, there is little or no oversight of the quality of care in ambulatory and other settings. Further, the Medicare program should adequately evaluate and fund its ongoing efforts to monitor quality of care.

HEALTH CARE REFORM

As Medicare continues to attempt to control growth in its spending, the interaction between Medicare's policies and those of other payers is increasingly important. Last year, in response to a request from this Committee, ProPAC submitted a report describing the steps necessary to implement an optional hospital payment system, based on Medicare's methods, that could be adopted by private payers. This report documented for the first time the extent to which hospitals were able to generate additional revenues from private payers to offset losses from Medicare, Medicaid, and uncompensated care. This phenomenon is frequently referred to as cost shifting.

Cost shifting is important to private payers because it increases their overall costs. It is also important to Medicare because it weakens Medicare's financial incentives to decrease overall costs. This report also showed the significant savings possible if private payers paid hospitals at rates closer to those used by the Medicare program.

ProPAC is continuing its analysis of issues related to controlling Medicare as well as total health care spending. As I mentioned earlier in my testimony, in July we will be reporting to Congress on issues related to the design and implementation of a global budgeting system with emphasis on its application to hospital and other facility services.

This completes my testimony, Mr. Chairman. I would be pleased to answer any questions you or the other members of the Subcommittee may have.

Chairman STARK. Thank you. You did mention that we have been grappling with the equity of hospital reimbursement and we have been fussing with area adjustments, and I think it wouldn't come as any surprise to you that many of us use things like indirect medical education as a proxy for helping inner-city hospitals. We have to write generic rules and then sit around and figure out how that is going to apply to specific hospitals.

The committee has been frustrated for a number of years about the unwillingness—it has to be unwillingness, because I can't believe that hospitals that can run heart transplant operations can't get their books straight. But we have been unable to get the hospital community to cooperate voluntarily with some kind of uniform reporting so that we can deal with the approximately 6,000 hospitals who I suspect have 6,000 different ways to keep books.

What I have always wondered is, if we had uniform statistics and if the Federal Government started to buy computers and get rid of the McBee key sort system that they use now, wouldn't we really be able to deal with hospital-specific problems? I am not suggesting that we would deal with the DRGs across the board, but it would seem to me that we would be able to compare. We can keep track of thousands of bombers and how many parts are in those and when they wear out and when they have to be replaced. It just seems that dealing with it on a hospital-specific basis might be the only way that we will get fairness. As somebody said, "Fair ain't simple." But that is a lot of hospitals. I would hate to suggest that the Comptroller of the Currency keeps track of almost that many banks, but more banks go broke than hospitals.

Is that something we should even consider, in your opinion, trying to—

Mr. ALTMAN. Absolutely. But I would go further than what you said and wouldn't only talk about changing the cost reporting, but I think we need to look at—

Chairman STARK. No, income reporting, total reporting.

Mr. ALTMAN. We need to look at the accounting principles.

Chairman STARK. Absolutely. I mean total reporting. None of this just show us your costs but don't show us the other side of the coin. That is nonsense.

Mr. ALTMAN. But, to be fair to the hospitals, part of this dates back to the Medicare program itself. If you go back in time in history—and I go back a fair number of years—you have to look back to the situation when Medicare was created, when accounting was this sort of how large a shoe box one used. The Medicare program needed to be quite flexible, not too rigid in the accounting principles it used. And so it allowed hospitals to use a variety of accounting principles, provided they were consistent.

So you have a number of what are considered legitimate accounting principles that hospitals can use. It is not that they are violating the law. They are just using different principles.

I think it is about time that we took a hard look at it and decided which is the best way of reporting the information, and make that the standard for the whole system. Then we need to go to this issue of reporting. And I am not here to blame anybody. I don't know whether it is the hospitals' fault or not. I think we bear certain responsibilities as well in the Government because I think we should

work with them and come up with an acceptable reporting system, and let's get on it. It is a very important issue, as you pointed out, particularly as we get tougher—you know, it is all right if you pay 50 percent more than anybody needs. You don't have to worry about it. But when you start paying 20 percent less, you have got to worry a lot about fairness. So I totally support you, Mr. Chairman.

Chairman STARK. Referring now to your earlier career in the days of the Nixon price freeze, it was necessary at that time to set up a bureaucracy, and we have heard, certainly read in the press, that we may be considering using cost controls, which I will refer to as the Medicare system and bureaucracy, or going to a freeze, which I presume would take a new organization of some size to administer that.

It has been suggested that imposing Medicare's rate methods would necessitate a huge new bureaucracy, and it also has been suggested that the hospitals couldn't survive with Medicare rates, but perhaps at something 30 percent higher they could.

Could you comment on those two?

Mr. ALTMAN. Well, first, let me just say a few things about our experience with price controls. It is true that in 1971 President Nixon imposed price controls throughout the economy.

Chairman STARK. I would call that a freeze—and I call Medicare controls, too, but go ahead.

Mr. ALTMAN. He didn't freeze the rates. He allowed doctor fees to rise by 2.5 percent, which was the level of inflation expected, and he allowed hospital rates to go up by 6 percent. So it wasn't a complete freeze.

Just a couple of things just to sort of set the record straight. First of all, it was a national emergency, and health care was treated like all others. However, when it was lifted for the rest of the economy, it was maintained for the health care industry because President Nixon did recognize in 1972 that health care was already on an inflationary cycle much greater than the rest of the economy.

It is true that during the period that the price controls were in effect, they did work to control the rate of spending. It is also true that when we took them off, health care spending jacked right back up to the old trends.

Now, that doesn't mean we shouldn't necessarily have put them on in the first place, but don't think that you can just put kind of a blanket over what is going on underneath it and when you take it off things change. I think one ought to be very cautious about using price controls unless you are going to evolve into something else that sort of makes sense.

I also would caution against using them for very long. I don't think there is any question you can impose price controls, either freezes or controls, for a short period of time and not do irreparable harm. But if you do it for a long time, you will distort the system. And I think there are better ways of dealing with reducing health care spending than price controls.

One last statement. Back in the early 1970s, much of the increase in spending was price driven. Now much of the increase in spending is volume driven. So don't expect that if you just introduce price controls we would be able to simply cut the rate of infla-

tion. Our estimates suggest that 50 percent, at least, of the extra increase in spending in health care—extra, beyond regular inflation—is volume driven. And so, at most, you are dealing with a quarter. And we also should recognize that if you introduce price controls, after a while the health care industry, after all, have some pretty smart people who work for it, and they will not just sit back and not figure out a way to get revenues other ways.

But, with all that said, if the President believes that this is a true national emergency similar to what President Nixon believed, then price controls could have a role for a short period of time. The extent to which a new bureaucracy would be needed depends on how much you start playing around with it.

During 1971, we didn't create a new bureaucracy. We had a couple dozen people over on M Street, and we made use of the Internal Revenue Service, which turns out to be a wonderful monitoring arm for the health care industry. Somehow they sort of find dealing with the Internal Revenue Service a source of concern, and it worked marvelously. So we actually had very few additional—we had no additional people during the economic stabilization program.

Now, things have changed. I think we have learned a lot since 1971. Those were pretty crude price controls. And I do believe we have learned a fair amount about how to do some form of controls through Medicare, whether it is PPS or the relative value scale.

As you pointed out at the end, though, I don't think you can just simply use the Medicare rates. Because if you did that, you would have serious financial hardship for most of American hospitals. And I think we would need to decide what the right rate is, whether a 30 percent differential or a 25 percent differential is appropriate.

We issued a report to you last spring which tried to look at this, and it deserves a much more thoughtful discussion. It is possible to do it. It doesn't come without its problems, though, and I would be the first to admit it. But if the President believes it is in the national interest and it is not—if it is done right, I don't think it would destroy our system. Of course, if it is done wrong, it could cause real problems.

Chairman STARK. To follow on, in the press we read, I think on Monday, that there were three principal programs being considered. The first one listed was some kind of voluntary agreement, which I will dismiss for you. Given the other two, which get us down to reality, one was basically to expand the Medicare system with adjusted rates for the private sector, and that would prevent, arguably, some cost shifting; or to go to a price control mechanism similar to the one we had back in the 1970s.

Which, in your own opinion, of those two would you suggest we might do?

Mr. ALTMAN. Well, my understanding about the options—actually, there was a third one which was to sort of freeze insurance premiums, and I think that would be a mistake, particularly in this environment which is volume driven. I mean, if you freeze insurance premiums, you are going to lead to a lot of serious problems.

Now, my preference—I understand why they want to go to the simple system. I have heard the arguments that the simple system

recognizes its temporariness, and if you want to put up a building that you don't expect to have very long, don't put too much time into building it up. That is the argument; make it sort of rickety so it will fall apart of its own weight.

I think we have learned a lot between 1971 and 1991 and 1992, and it would be a shame not to make use of the knowledge that we have learned in the Medicare program. But I would suggest that it still be temporary.

Chairman STARK. You could stop right there. But go ahead. [Laughter.]

Mr. ALTMAN. I just think it would be a shame. We have learned a lot. And if we do it wisely, the Medicare PPS system is a much more sophisticated and fairer system than just simply freezing everybody in place.

Chairman STARK. A final question. We have roughly estimated that in trying to reach our budget goal of a 5-year reduction of \$48.3 billion, through these suggested reductions which you have commented on we could get amazingly close, 49.6, by just maintaining 1993 prices for 2 years, a postponement of the COLA—I hesitate to use the word "freeze," but basically that is, I guess in the words of some, a quick and dirty option.

What do you believe the effect on hospitals would be if, to reach our budget goal, we just said let's hold prices for 2 years at the 1993 rates?

Mr. ALTMAN. Well, I think we need to be reasonable. I think there are a couple of things. First of all, if you hold hospital prices but don't hold hospital costs, you are going to put hospitals in a serious position. You know, there are a few hospitals around this country that I am sure have their subbasement full of money that they can use, but a lot of hospitals operate pretty close to the edge. And I think they have been part—it is not like they are the problem and the other part of the system is just fine. I think they face substantially higher costs.

It is all part of this kind of cycle where there is a lot of money out there in health care. Everybody is benefiting. So I think we ought to be very cautious, first of all, about freezing prices for very long without doing something about the cost structure which they participate in. Also, I don't know how long it would take to put them into serious financial jeopardy. If you freeze it for 2 years, if the level of inflation is fairly low it is not serious.

I don't know. Being the radical moderate that I am, I guess I wouldn't quite go so fast, so hard. I would like to just see their prices maybe rise by general inflation for a couple of years.

Chairman STARK. Well, let me phrase it another way, then. Let's suppose that now all you and I are arguing about is the update.

Mr. ALTMAN. Right. Well, in that update is a couple of billion dollars. That is not a trivial—

Chairman STARK. Yes, but let me suggest it a different way, then. Would it make any difference to you whether we just did it with an across-the-board update in the market basket without doing all the adjustments? I think Mr. Thomas was interested. Would that be as fair? What would the effect be, if you take into account the fairness issue, of doing it that way, or by continuing

to try to achieve a fairly substantial reduction on an item-specific or line-item basis?

Mr. ALTMAN. Let me remind the committee we are sitting there with 37 million Americans with no health insurance. In 1990, we estimated that hospitals provided these uninsured with \$10 billion worth of free care. My fear is that if a hospital is—if you do nothing about the uninsured while you are doing all this stuff and controlling hospital rates, the natural tendency, even giving hospitals the benefit of being as decent as the rest of us, they are going to face real pressure to cut costs. And it is very likely that the first place they are going to go to cut costs is to reduce the amount of uncompensated care.

So, therefore, I would be concerned about just flat—now, some hospitals don't provide it or provide relatively little uncompensated care, while others disproportionately bear the burden.

The reason why I like PPS and the reason why I like what this committee and the Congress has done, along with our help a little bit, in adjusting the Medicare payment is to recognize Medicare has a responsibility to help support those extra payments. Therefore, as we think about cutting the rate of increase of hospital rates, we need to be more and more concerned about its impact on those hospitals that treat large numbers of uncompensated care. Therefore, I would be very leery about doing it across the board.

I feel the biggest losers in the short run would be those people without insurance. My preference, therefore, is to first put everybody on an equal playing field, cover everybody first, then control costs, not do it the other way around.

I realize the tendency is to cut costs first so we can save the money to pay for covering the uninsured, but I have to be concerned—and I am sure you are as well, Mr. Chairman, as well as all the members of the committee—that if all of a sudden we took all the reserves out of hospitals, I don't know where they would get the \$10 billion to provide free care.

Chairman STARK. Thank you very much.

I would just like to suggest, whoever is running the clock over there, the chairman has exceeded by a great deal the time, and I am sure that you are all interested in inquiring. Why don't you run that up to 12 minutes?

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I think most of us were colorblind while you were talking. We didn't notice the movement of the colors.

Just to take another slightly different cut on the same question, Doctor, from the beginning I have been concerned, as someone who represents a large rural area, in terms of the problem of geography and the types of hospitals and getting it right.

Mr. ALTMAN. Right.

Mr. THOMAS. And we have been in the process of trying to get it right. You were going to do more on the equity question, and now we have got some cuts in front of us. Just a little bit of a comparison between where we would be in continuing to improve equity under the proposed cut structure versus, say, a 2-year freeze which produces at the end roughly the same dollar amount adjustment, but obviously locking into today's "equity." Do we have some room

for equity even under the reduced cuts in terms of continuing to try to get it right?

Mr. ALTMAN. Well, first of all, we are phasing in an increase, the relative increase in rural hospital payments, which we have supported, and there is a long history of the PPS unintentionally disenfranchising some rural hospitals because of volume and other factors. And through a 9-year period, we have been trying to make some appropriate adjustments. And if we froze in place that adjustment phase, I think it would hurt them, so I do believe we need to continue to go forward on those adjustments.

I would have to look. I——

Mr. THOMAS. You could still do it under the proposed reduced rate?

Mr. ALTMAN. Yes, sure. But if you just froze it——

Mr. THOMAS. It doesn't do it.

Mr. ALTMAN. I don't think we want to do that.

I would need to look at where this impacts if you just froze it. We haven't really worked out those numbers, but I think we owe it to our system that, before we support anything like that, we look at the implications and look them in the eye and say that is a system that we could live with after we have looked at it. And so I am not prepared to support just that kind of a freeze until I have looked at the implications.

Mr. THOMAS. In addition, Doctor, sometimes we have very technical phrases that we use here, and in your general response to the chairman about the transition, you indicated that until we moved to, I think it was something else that makes sense, I am in favor of that.

Mr. ALTMAN. That is a very technical phrase.

Mr. THOMAS. Yes. I don't know who is opposed to that. The problem is, what does it look like?

My concern, as I said at the beginning, in part is that we have kind of developed a pattern in dealing with budget deficits under the Budget Act on reconciliation of coming back to this subcommittee and this committee and financing a portion of the budget problem by ratcheting down Medicare. We are doing it this year at the same time we are supposed to be looking at an overall reform.

My worry is, are we going to do the same thing next year, the year after, the year after that? And at what point—and I guess my question is: In this something else that makes sense, do you see Medicare being subsumed under the larger something else that makes sense? Isn't it more difficult if we carry 2 or 3 more years down the line of diverging for pure budgetary purposes in making that crossover the transition in the blend? From your perspective, what makes the most sense in moving to something else that makes sense?

Mr. ALTMAN. In my testimony, I just touched on that. I agree entirely with your thrust. Medicare is now paying, on average, 10 to 12 percent below what hospitals perceive their costs are, and for many hospitals it is closer to 15 to 20 percent below.

Now, you know, we could have an interesting and important dialogue about whether it is Medicare paying too low or the hospital costs are rising too much. But the truth of the matter is, in the current environment, you have this differential between costs and pay-

ments, which is being made up differentially, depending on the ability of hospitals to shift their costs. I share your concern. You can do that for a while, and I don't know whether the current differential is too much or not enough.

Mr. THOMAS. But we have been doing that for a while.

Mr. ALTMAN. We have been doing that for a while.

A couple of points I would like to make. In many respects, we are using our inpatient system better than I would think any other country in the world. If you look at admission rates in this country compared to other countries, our admission rates are lower than any other country that I have looked at, except for Japan, and they have a—well, that is another story.

The second issue, we have the lowest length of stay by far in this country.

Third, if you look at Medicare, growth in inpatient use has been absolutely flat.

The problem in this country now in terms of growth and spending is on the outpatient side. I think we have got to be careful about beating the problem of the 1970s in the 1990s. In the 1970s, there was no question. You know, you shot all the darts you could at the inpatient side, and we figured if we solved that problem, we had it solved. Well, we solved that problem, and we don't have it solved.

So I am concerned about just focusing too hard on the inpatient side. I am concerned about focusing too much on Medicare without dealing with the broader issue.

So, yes, we need to—I am not saying we have to fold Medicare into the total system, but any system that we come up with to control health care spending should control all health care spending in a fairer way and not put a disproportionate burden on the Medicare or Medicaid programs.

Now, with that said—

Mr. THOMAS. That would include veterans as well?

Mr. ALTMAN. What?

Mr. THOMAS. That would include veterans as well?

Mr. ALTMAN. Well, I—sure. I mean, the question is—and, you know, you listen to the debate on veterans. Some people say it is the most efficient health care system we have, and some people say it is the worst health care system we have. I think we need to know a lot more about that veterans system before I would be prepared to answer that either way. You and I have talked about this, and I think we need to look at it. We need to uncover that part of the system.

So, in conclusion, Medicare needs to bear its share of the responsibility of controlling spending, but it should not be the battering ram that controls total spending.

Mr. THOMAS. Well, and it has been the cash cow for reconciliation, and it just seems to me as we continue to move in terms of the percentage that is, in essence, subsidized by the private sector, any bridging of that becomes more difficult the longer we continue the current pattern. And I see no real option given the current budgetary procedures, even though we might have a reform proposal presented to us, because we are not going to deal with that thing in 3 weeks. That is why I said at the beginning in terms of

the statement, we may or may not finish dealing with health care this year. We will be dealing with another budget.

Mr. ALTMAN. Yes. Looking at the total impact of the President's budget on Medicare, to be fair, it isn't really that serious a cut. They could have come at Medicare a lot harder. My sense is that they pretty much adopted a reasonably moderate approach at this first round. After all, what are they talking about? A 1-percent reduction below market basket for part A, for inpatient, some small adjustment on the capital side. You know, I am not saying it is trivial, but I think if you put it in the broader context, I would not view the cuts that have been suggested by the new administration as all that serious.

Mr. THOMAS. So they were looking at about \$48 billion. The Kasich Republican budget package was looking, total, at \$73 billion.

Mr. ALTMAN. That is what I am saying. As a matter of fact, it is actually less than theirs. So, you know, numbers grow very quickly when you start dealing in health care and Medicare, but in terms of percentages, it isn't that serious.

Mr. THOMAS. Thank you very much for your testimony.

I will pick up the gavel and recognize the gentleman from Wisconsin.

Mr. KLECZA [presiding]. Why do you think I am sitting here?

Mr. THOMAS. I don't think I am allowed to. They will never let me in the room with a gavel alone. I know that. [Laughter.]

Mr. KLECZA. I am the warden.

Doctor, I have a couple quick questions. Number one you indicated in response to Mr. Thomas that our inpatient growth has leveled off. However, hospitals are picking up additional revenues, I would guess, and activity in the outpatient section. What type of changes or recommendations do you recommend to curtail some of the costs that are now being shifted over to that outpatient section?

Mr. ALTMAN. Outpatient care is a much more complicated issue at several levels. First of all, when you deal with outpatient, you can't just deal with hospital outpatient. You have to deal with outpatient care, hospital, freestanding, home, physician's office, and so on.

Second, in the outpatient side, it is not the price increase; it is the volume increases.

Third, the quality measures that we expect of and we put in place on the inpatient side just doesn't exist on the outpatient side.

While all of us, every so-called expert, half expert, argue that we should reduce inpatient, that we would be better off by shifting the care to the outpatient side, both in terms of cost and quality, some of us are a little concerned that we may have done too good a thing. And it is not clear to me that all of the services that we have shifted to the outpatient appropriately belong in the outpatient side.

So we need to develop much better measures of the quality of care that is being provided on the outpatient side. We need to develop better price times quantity, volume measures that don't only focus on the hospital, but focus on free standing and so on.

That is why I have been supporting some form of a budgeting system. That is why I have been moving more toward more budgeting or capitation rates so that you have an entity that is concerned

about total spending, not just price. And I think that Medicare could learn in this context from what is going on on the private side.

Medicare hasn't done as good a job on capitation as the private side, and price controls just don't work very well on the outpatient side. They just don't.

Mr. KLECZA. The other concern I have is in your testimony as it relates to the wage index changes that you are advocating. I believe that you are going to be coming forward within a month or so with a document showing a new approach to calculate the wage index.

Mr. ALTMAN. Right.

Mr. KLECZA. Without releasing the entire report today, what type of shifting are we going to be seeing in that analysis? Dr. Young.

Dr. YOUNG. It depends compared to what. The analysis compares the new system prior to any geographic reclassification or with the current reclassification or the proposed rules. It is very important to say what shifting is occurring in terms of what base are you looking at.

If you are looking at the current system, it will improve significantly what is called the border problem, those hospitals that are on the border where one wage index is substantially lower than the other.

Mr. KLECZA. Now, are we talking urban versus rural borders?

Dr. YOUNG. No. Our approach would do away with all borders. So the geographic borders that are currently in place would be gone, and the hospital's wage index would be based on its wage prices as well as the wage prices of its 10 or so nearest neighbors. Under that system, every hospital would have a unique wage index, and that wage index would reflect only the labor costs in its immediate area.

Now, there would have to be some adjustments made in a few cases for very isolated rural hospitals, but for most hospitals in the country, this mechanism would work and would pay them the wage of who they are competing with for labor costs.

Mr. KLECZA. Fine. Thank you very much.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you.

You mentioned, in response to Mr. Stark's question, your concern that across-the-board freeze mechanisms could negatively impact the hospitals under the greatest pressure. As you heard, I earlier asked of HCFA what they think might be the impact of the proposed cuts on hospitals under pressure.

Do you have any thoughts on that?

Mr. ALTMAN. You mean the current, the budget as articulated? As I indicated just before you came in, Congressman Levin, the budget that was submitted by the President really is a fairly minor adjustment to the baseline. My sense is it goes from around 12.3 to 10.6.

Dr. YOUNG. Percent increase in Medicare spending; yes.

Mr. ALTMAN. It is about a 2-percentage-point adjustment. And it is not likely to seriously make it worse for hospitals that are in trouble, and I don't expect that you would—if that was the only

thing that was implemented, I don't think you would see much of a difference in the availability of care in this country or the quality.

Mr. LEVIN. The direct medical, the indirect medical proposals?

Mr. ALTMAN. Well—

Mr. LEVIN. When you take the whole package, you think the impact would be very minor?

Mr. ALTMAN. With respect to direct medical, the direct teaching adjustment, ProPAC hasn't focused as much on that. It has been given to our sister/brother commission, PPRC, to focus on that. We have begun to look at it and talk to them about it. I generally support, as Mr. Cardin indicated, the movement toward more primary care training, so I would like to see a reemphasis on that. I don't want to comment, though, on the total.

With respect to the indirect medical, we had recommended that the adjustment go from 7.7 to 7 percent, and then look at it and see whether it deserves a further adjustment. Our understanding of what the administration did is that they, in 2 years, drop from about 7 percent to about 5.6 percent, which is close to where we suggested we might end up after 3 years.

So I am not saying it wouldn't do harm to some teaching hospitals, but, you know, in the nature of making the system fairer, it is not a proposal that is off the wall. We had recommended that the amount be put back into the standardized amount for all hospitals. In the President's proposal, they just took that out to reduce spending. That is a political call.

So on net, I would not think that the proposals that the administration had put forth in their budget would do serious harm to our hospital system.

Mr. LEVIN. It would be helpful if, in the next few weeks, you could let us have any further information on the practical impacts. I don't know if you have had a chance to look at the testimony that is to follow, but essentially the suggestion is, as I read it, that whatever the theory in practice, we had better be careful that there isn't a relationship between the proposed cuts and occupancy, between the proposed cuts and uncompensated care.

Mr. ALTMAN. Yes.

Mr. LEVIN. That you are very concerned about injury to hospitals undertaking a lot of uncompensated care by an across-the-board mechanism. That very concern of yours would, indeed, be raised by some of the proposals before us. So it would be helpful.

Mr. ALTMAN. We will do that. We have looked extensively, partly on your urging, at the issue of focusing the teaching adjustment more on hospitals that really do provide uncompensated care.

Now, the first thing I would say is that when you look, some teaching hospitals in particular do a wonderful job, are really at the forefront of providing a lot of uncompensated care. The other side of it, there are hospitals that are receiving a big chunk, a substantial amount of teaching adjustment money that aren't providing anywhere near their share of uncompensated care.

So we had first made a recommendation last year about focusing the teaching adjustment only on hospitals that also received disproportionate share payments.

Newer analysis this year suggests that when you look at the extra payments that hospitals receive from the disproportionate

share adjustment and you look at the extra payments that now rural hospitals are receiving, the fairest way of taking the money that you save is to give it to all hospitals. We couldn't come up with a technique that would focus it any fairer. But in past years, we thought we should focus it only on hospitals that also were disproportionate share hospitals, we should decrease the teaching adjustment—not eliminate it, but have the teaching adjustment for teaching, but not disproportionate share, hospitals at the lower number and only give the higher amount to those hospitals which were only disproportionate share.

Mr. LEVIN. Any further guidance——

Mr. ALTMAN. OK.

Mr. LEVIN. We have been pressing you, and it is maybe a little worrisome that you are coming back and saying to us it is difficult to do anything.

Mr. ALTMAN. Well, I didn't say that. My sense is that the fairest way, based on where the money now goes, is that if you were going to reduce the teaching adjustment, the fairest way to do it would be to give it back to all hospitals. We are already doing a good job of focusing Medicare money on hospitals like disproportionate share and rural hospitals. We are doing a good job of doing that. If the rest of the health care system was doing as good a job as Medicare, we wouldn't have the problems we have.

Mr. LEVIN. The problem is that when you—and I am not saying these proposals are off the wall at all—dramatically reduce through direct or indirect medical education, that very much favors trying to build in a stimulus for primary care—there are some hospitals that are doing a lot and some who are doing very little—you are hitting the hospitals that are doing a lot, and we need to look at that.

Since the chairman was good enough to extend the time, let me engage you, since you have engaged in discussion of the overall health reform issues—I heard you several times—say one thing about what is the cart and what is the horse, and which do you put first, cost containment or the expansion of coverage? You make the argument that you should insure everybody first and then undertake cost containment.

For a lot of people that I represent, they tell me this in simple terms. All of you tell me about the immense waste in the system. Before you hit me for more dough, get rid of the waste.

And if I come back to them and say that in order to get rid of the waste, we have to insure everybody, the people that I talk to back in Warren, Mich., or Royal Oak, Mich., find that hard to buy. I would like to try to persuade you that that commonsense reaction has some considerable weight to it.

Mr. ALTMAN. It does in isolation, but let's take an institution, let's take a hospital. Now, for the sake of argument, let's say that that hospital has 10 percent waste, if you and I were going to go in there and say that is waste. But our definition of waste is protected by some elements in that hospital that are not weak.

Now you come along and you impose a 10 percent reduction in payments, and your hope is that if you impose a 10 percent reduction in payments, they are going to get rid of the 10 percent waste.

They are going to get rid of the 10 percent waste as you and I defined it.

My concern is that that isn't what is going to happen at all. They are going to go after the easiest way to control 10 percent of their costs, and my fear is that they are more likely to get rid of some of the uncompensated care than the 10 percent waste.

So if you go after them with a blunt object called a 10-percent cut in hopes that they are going to do all the right things, I think we are being unbelievably naive, even though that is what we would want.

Institutions have powers in them that we could postulate who the powers are, and I am sure if you ask them, they would think they are doing the right thing. But they are not going to let certain things be cut—but our definition would be that is waste. So my concern is—and we have seen it in the past—that when we put across-the-board limits on spending, it doesn't always generate reductions in what you and I or the people in your district would call waste.

Mr. LEVIN. No, but we maybe have to try to find a way to do that because for us to first insure everybody, you are going to have to find the money. And if it isn't going to come from—

Mr. ALTMAN. Well, let's do it at the same time. I understand. I appreciate the problem. But I need to caution you and others in positions of authority that if you go ahead and cut across the board payments without helping out those that are the most vulnerable, we cannot be assured that the cutbacks will not disproportionately go against them.

Now, that is just a warning. We can watch it. We can legislate and say they can't do it. We could try to protect them the best we can. But it is a warning.

Mr. LEVIN. And I think a fair one.

The red light is on. I think we are here by ourselves, and I think there is another vote.

Chairman STARK. Stuart, I would like to return to a previous question because I think I may have phrased it in a confusing manner.

The committee has been charged with saving \$49 billion out of Medicare over 5 years. We are going to have to do that one way or another. There are more alternatives, but let's just take these two. You are familiar with the list of line-item reductions in part A that the administration has suggested, and we are both aware that there are others. We could mix and match like a Chinese laundry list. But an alternative to that would be to hold the update to zero—I am not talking about a price freeze, but this would allow probably a residual of a 4 percent increase for hospitals in DRGs for 2 years, and that would raise the same amount of money.

Now, recognizing that we will revisit this issue one way or another in some kind of health care reform, would it make a great deal of difference in burden in being fair? Some hospitals say with the big cuts in medical education it would impact inner-city and disproportionate share hospitals more than just this across-the-board approach.

Now, with that attempt at restating what I was getting at, how would you feel about those two choices?

Mr. ALTMAN. Let me see if I understand. In other words, rather than a combination of the different adjustments that the administration has put forward, reduction in teaching, reduction in capital, delaying and so on, just put a freeze, no increase for 2 years.

Well, I don't know why you want to do that. It seems to me that the kinds of—where they have focused the four or five adjustments on the part A side are all in areas that have some legitimacy.

Chairman STARK. No question.

Mr. ALTMAN. So to get the same amount of money, I think there should be that kind of targeting of the cuts as opposed to just the freeze.

Now, if you ask me what will it do, I think it will increase the cost shifting if you just do that, you do nothing on the private side, those hospitals that have the ability to shift further would shift further, and those that don't will bear the brunt more than others.

Chairman STARK. Would that take place under the line-item approach as well?

Mr. ALTMAN. True. True. Now, you know, who is going to benefit, one or the other. I think if you freeze it, it will have somewhat less impact on the teaching hospitals. I guess that will probably be the major difference if we ran the numbers, hospital by hospital or group by group, the impact probably would be fairly small, except for a few targeted institutions. New York—well, if it affects New York negatively, what can I say? I can't say anything against New York.

Chairman STARK. I think that inner-city hospitals, the few that we have tried to run where we have numbers—

Mr. ALTMAN. Well, inner-city hospitals, the program doesn't hurt the disproportionate share hospitals. It hurts the big teaching hospitals. And they have also been the biggest benefactors of the PPS program. On the other hand, their total margins are lower.

It is worth looking at. It is definitely worth looking at.

Chairman STARK. Of course, you know, you leave me an opening. Maybe one of the things to do is to do that and then add the restriction on the private hospitals as well. If we are in for a dime, we are in for a dollar. Let's get it all done at once.

Mr. ALTMAN. Well, we had proposed a less severe cut in the IME than the administration. We proposed just going from 7.5 to 7 and stopping, and then taking another look at it. They go over 2 years from 7.7 to 5.4 or 5.6.

One less severe or middle ground would be to go to 7 and then take the differential and reduce the update proportionately.

Chairman STARK. And I suspect that in our deliberations we will get into that kind of a routine, but then the minute you don't save a few billion there, we are running around looking for it elsewhere.

Mr. ALTMAN. Well, then, I would do what you said, and I would make the update—you could lower the update. Rather than minus 1, it could be minus 1-point—whatever the differential would be. You would have to figure out the math.

Chairman STARK. Are you convinced or would you have any numbers that show how much of this \$49 billion will get shifted, and how rapidly? Do you have any indication from past budget changes how much of that—

Mr. ALTMAN. Only indirectly. Hospital profit margins over the last several years have actually gone up, or at least maintained themselves. It is going to vary depending on the kind of institution we are talking about. Some hospitals have a fairly small percentage of private patients, so they can't do it. Others are in a much more competitive environment. And surprising as it may seem, actually some of the private sector payment groups are getting tougher, and they are not just accepting any increases without fighting back.

So I think the ability to cost shift is getting harder for institutions to engage in, but others have been able to erase one line and increase the other line. It has been fairly quick for some.

Chairman STARK. Well, I thank the both of you. I suspect we will be in touch with you quite frequently in the next month or two while we try and—

Mr. ALTMAN. Again, it has been our pleasure to work with you and your staff, and we welcome the opportunity. Thank you very much.

Chairman STARK. As always, it has been a pleasure.

The committee will stand in recess for about 10 minutes.

[Recess.]

[Questions for the record from Representative Grandy to Mr. Altman and his responses follow:]

Question. Dr. Altman, is the administration's proposal to reduce the average hospital update to MBI minus 1 percentage point for fiscal years 1994 and 1995 consistent with your March 1 recommendation?

Answer. ProPAC's recommendation for the update factor for fiscal year 1994 is 3.6 percent, which is market basket minus 0.7 percent on average. To continue with the elimination of the differential between the rural and the other urban standardized amounts, ProPAC recommends that the update for large and other urban hospitals be market basket minus 0.9 percent and for rural areas, market basket plus 1.6 percent.

Question. In your judgment, what impact will the administration's proposal have on the elimination of the urban-rural differential?

Answer. The administration's proposal is market basket minus 1 percent for fiscal years 1994 and 1995. The proposal is silent regarding differential updates for urban and rural hospitals. Under current law, the elimination of the differential between urban and rural hospitals is scheduled to be completed by fiscal year 1995. If no change is made in this law, the administration's proposal would mean a somewhat lower update for urban hospitals and a higher update for rural hospitals, and the elimination of the differential would continue. If the administration wished to give urban and rural hospitals the same update, current law regarding the elimination of the urban and rural differential would have to be changed.

Mr. LEVIN [presiding]. Let's recommence. We are going to have a pretty punctuated morning and early afternoon, I am afraid, because of the picture on the floor. But we will do the best we can.

My colleagues who aren't here, of course, have your testimony, and we will all review it in one way or another.

All right. Mr. Pollack, from the Hospital Association, accompanied by Mr. Bentley, you are here. And Mr. Gage from the National Association of Public Hospitals, and Dr. Foreman from the Association of American Medical Colleges.

As you know, under our rules, your testimony is in the record. It might be I think particularly useful—did you hear the testimony earlier? All of you were here?

Mr. POLLACK. Yes.

Mr. LEVIN. If you would like to comment on it as part of your remarks, that is sometimes particularly useful. So we will start with Rick Pollack.

STATEMENT OF RICK POLLACK, EXECUTIVE VICE PRESIDENT FOR FEDERAL RELATIONS, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY JIM BENTLEY, SENIOR VICE PRESIDENT FOR POLICY

Mr. POLLACK. Thank you, Mr. Chairman. I would like to make three points very briefly.

First, we are obviously concerned about the impact of further Medicare savings on hospitals and the communities they serve. While we appreciate and understand the need for shared sacrifice by all Americans, including hospitals, it is also important to recognize that these budget proposals will create genuine hardship, particularly to many small rural and inner-city urban hospitals who are already in financial peril.

According to ProPAC's figures, average PPS operating margins in 1990 were a negative 8.3 percent, with over two-thirds of the Nation's hospitals subsidizing the cost of treating Medicare patients. I might add that those figures are 2 years old, and the trend lines continue downward.

Clearly, these new budget proposals that delay and reduce update factors, cut graduate medical education, and further reduce outpatient payments will exacerbate the situation.

It is also important to recognize that hospitals have already contributed significantly toward deficit reduction over the past decade. The last reconciliation bill alone, enacted in 1990, reduced Medicare hospital payments by \$16 billion over a multiyear period yet to be completed.

Nevertheless, as a practical political matter, Mr. Chairman, we understand that this committee must meet the savings mark directed by the Budget Committee, and we hope to work with you in developing a fair, responsible, and balanced package that is sensitive to the legitimate needs of our most fragile institutions serving our most vulnerable populations.

At the same time, we must insist that any short-term budget actions be inextricably linked to the development of a health care reform package that provides both universal access and a restructuring of the health care delivery system.

Speaking of reform, my second point is that on this 10th anniversary of the prospective payment system, if—and I say if—we need to begin a second decade of Medicare savings, it must be achieved through a real reform rather than continued tinkering with a severely broken system. As you know, AHA has called for a radical restructuring of the delivery system which would result in about as much change, if not more change, in the way hospitals and doctors operate than virtually any other reform plan put on the table. It involves providing strong incentives to establish community care networks.

These networks would link together providers and other stakeholders to provide all services needed by patients, from preventive care to long-term care, and they would give patients a single entry

and coordination point for all services financed through integrated payment or capitation.

On the other hand, attempting to improve the current system by puttering and achieve further efficiencies through ratcheting is like driving a car by looking through the rearview mirror when we should be looking out the windshield. The hard truth is that if, in fact, additional Medicare savings are needed to keep the trust fund viable in the long term, we need to create a more efficient delivery system for Medicare beneficiaries, as well as all citizens.

I am pleased to see that ProPAC recognizes certain critical elements of this situation. Recommendation three addresses the need to control spending across sites of care by improving the continuum of care for Medicare beneficiaries and reining in the fragmentation of services. Our notion of community care networks moves exactly in this direction.

A thoughtful restructuring of the health care delivery system that includes Medicare and provides beneficiaries with a seamless system of health care security would generate savings. It would generate savings by addressing the inefficiencies that result from the overlap in duplication of services. It would address the issue of excess capacity. And it would address the inefficiencies created by the perverse incentives of our fee-for-service system that result in more and more services generated in the name of piecework and fewer and fewer services provided in the pursuit of wellness and prevention.

In conclusion, my third point is that also as a practical matter, we recognize that PPS will not go away overnight, and there are some stopgap measures that should be taken to preserve equity in the system. In this regard, we applaud ProPAC's work in refining the area wage index by moving toward a nearest-neighbor approach, and we look forward to reviewing the details and examining the impact analysis. And while we support the movement toward cost outliers, we believe there should be an extended phase in to cushion the detrimental impact that some hospitals will experience as a result of this change.

Finally, we are very supportive of the provisions in H.R. 21.

Thank you for giving me this opportunity to share our views with you. We look forward to working with you not only in regard to the short-term issues, but on the paramount issue of enacting meaningful health care reform that gives every single American a dignified entry point to the health care system and to a new and more efficient delivery system.

Thank you, sir.

[The prepared statement follows:]

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Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives
on
The President's FY 1994 Budget and FY 1994 ProPAC Recommendations

March 18, 1993

SUMMARY

- The American Hospital Association (AHA) is very concerned about the impact--on hospitals and their communities--of the Medicare savings proposed in President Clinton's Fiscal Year (FY) 1994 budget.
- Reductions in the Prospective Payment System (PPS) update, delaying that update until January, cutting both direct and indirect medical education payments, and continued reductions in payment for outpatient services will exacerbate the situation for many already financially troubled hospitals.
- Moreover, hospitals have contributed to deficit reduction in every recent budget reconciliation package.
- It is imperative that whatever budget savings are ultimately enacted, they be linked to the long-term goal of a health care reform package that provides both universal access and a restructured delivery system.
- Until this systemic reform becomes a reality, we must continue to seek fairness in the current Medicare system.

Mr. Chairman, I am Rick Pollack, Executive Vice-President for Federal Relations at AHA. I am accompanied by Jim Bentley, Senior Vice-President for Policy. On behalf of AHA's 5,300 institutional members, I am pleased to testify today on the President's FY 1994 budget proposal and on the March 1, 1993 "Report and Recommendations to the Congress" of the Prospective Payment Assessment Commission (ProPAC).

I would like to cover three basic points in my testimony this morning. First, the AHA is very concerned about the impact further Medicare savings--either those in the President's plan or those recommended by ProPAC--will have on the nation's hospitals and the communities they serve. Second, although some short-term budget savings may be

necessary, it is imperative that they be linked to the long-term goal of a health care reform package that provides both universal access and a restructuring of the delivery system. Finally, while we work on real reform, we must address the need for fairness and accuracy in the current Medicare program; both ProPAC and members of this committee have made important recommendations in this regard.

As you know, the Administration's FY 1994 budget proposal for Medicare is one part of an economic package that aims to stimulate the economy, create long-term job growth and reduce the federal budget deficit. We support these goals and believe it is in the best interests of the communities we serve that the nation's economy gets back on track. We further recognize that a strong economy generates job growth and health coverage in the private sector. To achieve deficit reduction and economic growth, the President has asked for sacrifices to be made. We understand that hospitals need to participate in the shared sacrifice required of all Americans in the short term to attain our shared long-term goals.

Yet, as we work toward these laudable goals, we must ensure that the sacrifice is fair and that budget decisions lead toward, not away from, a solution to our nation's health care crisis. To accomplish real and fair health care reform, everyone needs to understand how budget decisions made today will affect hospitals and their communities.

In May, when the President presents his comprehensive health care reform plan to the Congress and the American public, we will all be engaged in an important discussion about the future of our nation's health care system. While we look forward to that dialogue and are eager to work with this subcommittee and the Congress, we must ensure that existing federal programs do not undermine providers' ability to meet the legitimate needs of their patients. Purely budget-driven decisions can exacerbate our nation's health care problems and weaken the infrastructure upon which a reformed system must be built. Consequently, we need to carefully examine both President Clinton's FY 1994 budget proposal and the FY 1994 ProPAC recommendations in terms of their impact on hospitals and the communities they serve.

MEDICARE SAVINGS IMPACT

The President's budget proposal calls for nearly \$60 billion in savings for Medicare and Medicaid over the next five years. This comes at a time when ProPAC estimates that for FY 1929 the aggregate PPS margin--for both urban and rural hospitals--was negative 8.3 percent and AHA estimates that for FY 1993 two-thirds of the nation's hospitals were forced to subsidize the cost of treating Medicare patients.

Many vulnerable hospitals provide the only access to health care services for specific populations such as the poor, elderly and rural Americans. While citing the need to limit the rise of Medicare inpatient hospital payments, ProPAC's report also acknowledges that, "PPS payments should continue to increase at a reasonable rate, recognizing costs beyond hospitals' control." Reductions in Medicare spending have exacerbated shortfalls between payments and costs in ways that hospitals cannot sustain.

UPDATE FACTOR/CAPITAL

The President's budget proposal delays the FY 1994 PPS update by three months until January 1, 1994, limits the growth in these factors for FYs 1994 and 1995, and extends the 10 percent reduction in capital payments. Clearly, these proposals would exacerbate an already difficult situation for those institutions experiencing losses and place increased pressure on their ability to continue providing high quality services.

OUTPATIENT PAYMENTS

The proposals offered by the Administration serve only to further fragment outpatient payment policies without taking any steps toward comprehensive reform. Continued tinkering with the numerous payment systems currently used to pay for outpatient services meets short-term budget needs only. While we look forward to examining

the Administration's proposal for reform of outpatient payment, we believe that only with systemic reform will these issues be adequately resolved.

GRADUATE MEDICAL EDUCATION

The President's budget proposes significant cuts in payments to hospitals that train physicians. First is a reduction in indirect medical education payments, provided to cover the indirect costs of running teaching programs. It has long been recognized--and deemed appropriate--that these payments also compensate for the additional costs associated with the patients these hospitals treat. In the context of their broader mission of education, teaching hospitals typically care for a greater number of indigent patients and those with higher severity of illness. Care must be taken before further reducing this adjustment without enacting simultaneous access reforms to ensure that these patients continue to receive appropriate care.

Second, the budget recommends basing direct medical education payments on a national per resident amount--using resident salaries only--and further modifying payments by differential weighting depending on choice of specialty. We understand the need to implement incentives to train more primary care physicians, but do not believe that paying hospitals less for training other physicians is the incentive that will most affect the choices of graduating medical students. Only long-term, comprehensive reform of the delivery and financing of health care will properly align incentives in the direction of primary care.

These cuts in graduate medical education could exacerbate the financial situation of teaching hospitals--many in our nation's inner cities--where residents in training provide a large portion of the care to the medically indigent. The Association of American Medical Colleges will present detailed testimony at this hearing on these issues. We share their commitment to protect those vital hospitals.

PAYMENT FOR INPATIENT RADIOLOGY, ANESTHESIA AND PATHOLOGY

AHA is encouraged by the Administration's apparent commitment to aligning hospital and physician incentives as a method of controlling spending across all sites of care. In fact, a bundled payment is consistent with our vision of reform and the need for integrated payments. However, until these incentives are broad-based and the delivery system is restructured at the local level by collaborative arrangements among hospitals and physicians, hospitals should not be unfairly burdened by a federal requirement imposing a new relationship on hospitals and their medical staffs.

These proposed Medicare hospital savings in the President's plan total nearly \$22 billion for FYs 1994-1998. They must be viewed, however, in a broader context. Hospitals have made significant contributions to deficit reduction in past budget bills; Medicare hospital savings in the Omnibus Budget Reconciliation Act of 1990, for example, totaled almost \$16 billion.

Despite the magnitude of these savings, this year presents us with an opportunity we have not had in past years. It is imperative that whatever budget savings are ultimately enacted in the short term are accomplished fairly and that we remain focused on the long-term goal of meaningful reform that achieves universal access and a restructured health care delivery system.

Further, we must ensure that these measures do not freeze the current fragmented health care system in place. The solution to our nation's health care crisis is not in tinkering with current flawed payment systems such as Medicare PPS. Indeed, meaningful health reform can only come about through universal access and restructuring both the financing and delivery system to encourage more prudent and appropriate behavior by providers, payers, and consumers at the local level. Only in this way will we achieve universal access to needed services at a cost this country can afford.

AHA'S VISION FOR HEALTH CARE REFORM

The AHA's top priorities are achieving universal access and restructuring health care delivery around Community Care Networks.^{5M} These networks would be consortia of

hospitals and other institutional providers, physicians and other health care professionals, insurers, employers, unions and others groups.

Networks would be expected to provide patients with a broad, coordinated continuum of care, focused on improving the health status of their enrollees. In return, community care networks would be paid on a capitated basis, receiving a fixed annual payment per individual. The allocation of resources among providers within the network, including the method and level of payment to various participating providers, would be determined within each network.

Networks would give providers greater freedom to make decisions without micro-management by government payers and insurers. In exchange, networks must be accountable. Networks might provide regular reports to communities on health status improvement, patient satisfaction, and provider satisfaction with network relationships.

The AHA believes that community care networks hold the best promise for reducing inappropriate competition within our system; improving patient care; and eliminating unnecessary care, duplication of services and excess capacity. Restructuring our health care system into capitated networks will increase the focus on preventive and primary care services.

TRANSITIONAL ISSUES

While we work toward reform, hospitals must continue to operate under the PPS. In its March "Report and Recommendations to the Congress," ProPAC makes a number of recommendations regarding the accuracy and fairness of the Medicare prospective payment system.

LABOR MARKET AREAS

The movement away from the use of metropolitan statistical areas (MSAs) to define labor areas, and toward a definition more specifically representative of local labor costs is a much needed conceptual improvement. We would expect such a modification to minimize the differences in wage index values between neighboring areas and to prevent the grouping under a single wage index of hospitals separated by several hundred miles, as is currently the case for many rural hospitals.

AHA appreciates the complexity of the task ProPAC has undertaken in trying to identify more appropriate labor markets and feels that they have made excellent progress in this direction. We look forward to additional details on the methods as well as further impact analyses to determine the appropriateness of the significant payment redistributions that such a change would likely entail.

OUTLIER PAYMENT

The AHA continues to support *measured* movement away from day outlier payments, toward a greater emphasis on cost outlier payments. ProPAC's recommendation to completely eliminate day outlier payments within three years, however, would cause severe disruption of payment for a significant number of hospitals. We feel that any such change should be phased in over a longer period.

The suggested increase in the outlier pool to six percent of total PPS payments (from the current 5.1 percent) should be deferred until the effects of eliminating the day outlier payment are better understood and there is real assurance that all currently reserved outlier funds will be fully disbursed.

PPS EQUITY

In discussing equity adjustments to the existing Medicare system, we must not forget the numerous proposals contained in H.R. 21, the Miscellaneous and Technical Medicare Amendments of 1993. AHA applauds Chairmen Rostenkowski and Stark and other members of this subcommittee for their continuing efforts to enact these important legislative provisions.

H.R. 21 reauthorizes the Essential Access Community Hospital program, provides for separate payment for the interpretation of EKGs, phases in changes in outlier payments, and contains important provisions to assist hospitals with Medicare dependent and rural referral center status to keep that status until the urban/rural differential is eliminated. AHA fully supports this bill and urges the subcommittee to include its provisions in your reconciliation package. Like ProPAC, we continue to support the elimination of the urban-rural differential by October 1, 1994, as mandated by Congress.

CONCLUSION

As America's hospitals prepare for health care reform they must continue to operate under the current system, complete with a flawed and inequitable Medicare program. Both ProPAC and members of this subcommittee have supported important improvements to PPS. We stand ready to work with you to achieve these goals as well as to make the difficult choices required to meet the President's goal of a stronger economy. The President has asked for shared sacrifice from all Americans, including the nation's hospitals--many of which are financially vulnerable because of continued tinkering and past deficit reduction efforts.

ProPAC's report is critical of the fragmentation of the current health care system and calls for real coordination in order to control health care spending. The AHA appreciates ProPAC's approach to the long-term problems of the current system and supports their efforts to address central payment problems and avoid unnecessary tinkering.

We have worked with our members to develop a constructive approach to respond to the nation's health care crisis and look forward to working with you and the Administration in the months ahead. AHA is committed to meaningful health care reform that achieves universal access and a restructured health care delivery system.

SM - CCN, Inc. and San Diego Community Healthcare Alliance use the name Community Care Network as their service mark and reserve all rights.

Mr. LEVIN. Thank you very much.
Mr. Gage.

**STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL
ASSOCIATION OF PUBLIC HOSPITALS**

Mr. GAGE. Thank you very much, Mr. Chairman. I will try to be as brief as Mr. Pollack.

I am Larry Gage, president of the National Association of Public Hospitals. NAPH members include over 100 of America's metropolitan area public and private safety net hospitals.

I am very pleased to have this opportunity to testify today on the President's proposed economic plan. My prepared testimony also brings you up to date on a situation of America's urban safety net hospitals. We comment on health care reform, and we also call your attention to the more immediate needs, including serious capital infrastructure needs, facing America's urban health safety net. I will submit this for the record and summarize it briefly.

Let me illustrate the urgency of the situation of America's urban public hospitals with a few simple facts.

First, safety net hospitals are bursting at the seams. Such hospitals are providing today an extraordinary volume of inpatient and outpatient care. Just 72 NAPH members across the country averaged 260,000 emergency room and outpatient visits and 18,000 admissions in 1990, or over 10 times the volume of the average American hospital. These hospitals totaled 18.7 million emergency and outpatient visits in 1990. They operated at an 82 percent occupancy rate, also far higher than the rest of the industry, with many approaching 100 percent.

I have three brief charts that I wanted to show you today. The first chart indicates that safety net hospitals are both the hospital and family doctor for the uninsured. We are, in effect, national health insurance today. Forty percent of all NAPH member discharges were for Medicaid, and 33 percent of all discharges were self-pay patients in 1990.

As the second chart indicates, 48 percent, or nearly half, of all outpatient and emergency room visits were uninsured in 1990.

Finally, as the third chart indicates, safety net hospitals are uniquely reliant on governmental funding sources. Just 17 percent of the gross revenues of these hospitals were derived from private insurance and only 18 percent from Medicare in 1990, while over two-thirds were attributable to Medicaid and self-pay or no-pay patients.

As a result of this safety net role and narrow funding base, the many communitywide services provided by safety net hospitals are in danger of deterioration today. Trauma centers, high-risk obstetric units, emergency psychiatric units, emergency drug abuse treatment programs, burn centers, neonatal intensive care units, all are overflowing at a time when State and local budget crises often require reductions, not increases, in funding.

Having said this, despite—or perhaps because of—this bleak situation, NAPH supports President Clinton's economic plan. We believe it should be given an opportunity to work.

Our members made this decision fully cognizant that the President's plan includes a number of health-related spending reduc-

tions that will affect them directly or indirectly. We are those inner-city hospitals that everybody has been talking about this morning.

Nevertheless, we accept the spirit in which this proposal has been made, a spirit of healing, of change, of shared sacrifice, and of laying the groundwork for broader health system reforms.

Moreover, we believe that all three major components of the plan are essential to its success, including the proposed economic stimulus package, as well as tax increases and spending reductions. We would be far more likely to oppose a package that focused on spending reductions alone without addressing the other two areas.

In supporting President Clinton in this effort, NAPH is fully aware that some of the health-related spending reductions will hurt. In particular, reductions in Medicare medical education and capital payments will affect those urban hospitals who rely disproportionately on governmental funding sources and who have relatively fewer privately insured patients to whom uncompensated costs can be shifted, as Stu Altman pointed out this morning.

In moving ahead to enact these and other aspects of the President's plan, we thus ask only that the Congress be sensitive to the uneven playing field on which both patients and providers find themselves today. In addition, while we are prepared to support the President's proposed health-related spending reductions, we also urge the committee to tie those reductions directly to the financing of needed reforms.

I would be happy to submit the rest of my statement for the record and to answer any questions you may have.

[The prepared statement and attachments follow:]

Statement of Larry S. Gage
President

National Association of Public Hospitals

before the

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington D.C.
March 18, 1993

I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH's members include over 100 of America's metropolitan area safety net hospitals. These 100 institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over \$14 billion, these hospitals provide over 65% of their services to Medicaid and low income uninsured and underinsured patients. In other words, these hospitals already serve as "national health insurance" by default in most of our nation's urban areas.

I am pleased to have this opportunity to testify before the Committee on the President's proposed economic plan. I would also like to comment on the needs and concerns of urban safety net hospitals with respect to national health reform.

In particular, I would like to accomplish four things in my testimony this morning:

- First, I would like to bring you up to date on the situation today of America's urban safety net hospitals, including the substantial and increasing volume of services they provide to the poor and uninsured and the growing crises they face in maintaining their services, funding sources and infrastructure.
- Second, I will comment briefly on the President's proposed economic recovery plan -- to indicate NAPH's support for that plan.
- Third, I will set out a number of NAPH's recommendations and concerns with respect to national health reform, to assist you in preparing to consider the recommendations that will soon be forthcoming from President Clinton and any other plans that may be on the table.
- Fourth, and finally, I would like to call your attention to the more immediate needs, including serious capital infrastructure needs, facing our nation's urban health safety net. I would also like to urge your support, in both the short and long term, for programs to guarantee the continued viability of this safety net, so that our nation's urban residents will have access to needed health services WHETHER OR NOT they are ultimately covered under any national health plan.

THE SITUATION OF AMERICA'S URBAN HEALTH SAFETY NET

The level of current attention in Washington D.C. and in many states to comprehensive health care reform has never been more welcome or necessary. The urban health safety net that has historically provided the great majority of health and other services to the uninsured is increasingly threatened today by a combination of factors.

Let me illustrate the urgency of this situation with a few simple facts:

- **The numbers of uninsured have dramatically increased in recent years.** Despite all our rhetoric about reform, the number of completely uninsured Americans grew from 34 million uninsured in 1988 to 37 million last year. It is also now estimated that another 60 million are insured only part of the year, or have health insurance that will prove inadequate in the event of a serious illness. This is not just a temporary trend brought on by the recession: it has been exacerbated by disturbing trends among employers and insurers to reduce or eliminate coverage for many among the insured, including dependents, retirees, and individuals with AIDS and other serious medical problems.
- **Safety net hospitals are bursting at the seams.** Such hospitals today are providing an extraordinary volume of inpatient and outpatient care. 72 NAPH member hospitals across the nation averaged 260,000 emergency room and outpatient visits and 18,000 admissions in 1990 -- or over ten times the volume of the average American hospital. NAPH member hospitals totalled 18.7 million emergency and outpatient visits in 1990. NAPH members averaged an 82% occupancy rate in 1990, also far higher than other hospitals, with many safety net hospitals approaching 100%.
- **Safety net hospitals are both hospital and family doctor for the uninsured.** In 1990, 33% of all discharges and 30% of all inpatient days were not sponsored -- even by Medicaid -- in NAPH member hospitals; 48% of all outpatient and emergency room visits were also uninsured.
- **For some safety net hospitals, these proportions are far higher.** At San Francisco General Hospital, 62% of all inpatient days and 72% of all outpatient visits were not sponsored; for Dallas' Parkland Memorial Hospital, the figures were 54% of inpatient days and 62% of outpatient visits.
- **Safety net hospitals are uniquely reliant on governmental funding sources.** Just 17% of the gross revenues of safety net hospitals were derived from private insurance and 18% from Medicare in 1990, while 67% were attributable to Medicaid and "self pay" patients (an average of \$73 million in Medicaid revenues and \$69 million for "self pay" patients (who are typically uninsured and thus "financed" by direct subsidies and other mechanisms such as Medicare and Medicaid disproportionate share adjustments).
- **Emergency and clinic patients are waiting longer to see doctors or be admitted.** 58% of NAPH hospitals reported periodic waits by emergency department patients of 12 hours or more for admission, and half of all hospitals surveyed reported that some patients were forced to wait more than 24 hours.
- **The many community-wide services provided by safety net hospitals are in danger of deterioration as well.** Trauma centers, high risk obstetric units, emergency psychiatric units, emergency drug abuse treatment programs, burn centers, neonatal intensive care units -- all are overflowing, at a time when state and local budget crises often require reductions, not increases, in funding.

In short, while Congress debates how to provide access to care, the nation's Safety Net hospitals are providing that care now, and they are providing it to more and sicker people than at any other time in our nation's history.

COMMENTS ON THE PRESIDENT'S ECONOMIC PLAN

NAPH supports President Clinton's economic plan.

Our members fully recognize that the President's plan includes a number of health related

spending reductions that will affect them directly or indirectly, as well as many tax provisions that will also affect their employees personally. Nevertheless, we accept the spirit in which this proposal has been made -- a spirit of healing, of change, of shared sacrifice, and of laying the groundwork for broader health system reforms. Moreover, we believe that all three major components of the plan are essential to its success -- including the proposed economic stimulus package as well as tax increases and spending reductions. We would be far more likely to oppose a package that focussed on spending reductions alone, without addressing the other two areas.

In supporting President Clinton's effort, NAPH is fully aware that some of the health-related spending reductions will hurt. In particular, reductions in Medicare medical education and capital payments will affect those urban hospitals who rely disproportionately on governmental funding sources and who have relatively fewer privately insured patients to whom uncompensated costs can be shifted. In moving ahead to enact these and other aspects of the President's plan, we thus ask only that the Congress be sensitive to the uneven playing field on which both patients and providers find themselves today. In addition, while we are prepared to support the President's proposed health-related spending reductions, we also urge the Committee to tie these reductions directly to the financing of needed reforms.

NAPH also strongly supports targeting at least some portion of the proposed economic stimulus package on rebuilding the urban health infrastructure, in order to improve access to essential health services and facilities in our nation's inner cities. In addition to the broader need for long term capital assistance spelled out in my testimony below, urban safety net hospitals have identified a large number of smaller projects that are ready to go immediately. Those include building or expanding trauma centers and emergency facilities; renovating facilities to respond to the sudden resurgence of tuberculosis; the creation of new high risks pregnancy centers; and needed renovations to meet fire and life safety code standards. A list of specific urban infrastructure projects that are ready to go almost immediately is attached to my testimony. At a minimum, in addition to the small amount that has already been set aside for health programs, we urge this committee to recommend expressly including health care facilities among the projects that are eligible for broader stimulus spending.

NAPH COMMENTS ON HEALTH CARE REFORM

Our failure to provide universal health coverage and access to care has for years been the single most glaring deficiency of our nation's health system -- one we share only with South Africa among Western nations. In the past two decades alone, there have been over a dozen major national health insurance initiatives, offered by the most important political leaders of our era, as well as scores of more modest proposals. Unfortunately, each of these proposals has generated influential opposition as well, virtually paralyzing all efforts to achieve needed reform. As a result, we have advanced very little in this arena since the enactment of Medicare and Medicaid.

Our nation's lack of universal health coverage is forcing safety net hospitals to treat an ever-broader population of Americans who have no access to other providers because they have lost their jobs, their insurance, or both. Rarely are these individuals able to become eligible for Medicaid -- yet rarely can they afford the cost of a serious illness either.

Being a relatively small organization, NAPH did not choose in the past to adopt a single, comprehensive proposal of our own, but rather to outline the characteristics we would like to see in any national health plan that is adopted by the Congress, or by a state. Those principles are set out in an attachment to my testimony. More recently, with the dramatic improvement in the prospects for health reform, NAPH has chosen to expand on those general principles -- to offer more specific and detailed suggestions in a number of areas, based on our intimate knowledge of the health status, and the broad range of both health and social needs, of America's urban uninsured.

While NAPH's specific health reform proposals are still under development in several areas, our work to date -- and our vast experience serving presently uninsured patients -- permits

us to make the following observations and recommendations at this time:

1. ELIGIBILITY

A. The goal of national health reform must be nothing less than **universal and mandatory coverage for all residents**. While universality is generally acknowledged as a worthy goal, there appears to be debate over whether coverage should be voluntary or mandatory for employers, employees and the uninsured. The experience of NAPH members in many states makes clear that voluntary coverage will simply fail to reach many among the uninsured -- including many of the most vulnerable individuals and families. It is well accepted that in many states, the Medicaid program (which is voluntary) enrolls less than half of all potentially eligible patients. Only by requiring all individuals to be covered can a new system lead to genuine reforms.

B. It will clearly be necessary -- if only for budgetary reasons -- for universal health coverage to be phased in. In that case, it is important that **the most vulnerable populations among the uninsured should be covered first** -- including the chronically or seriously ill, as well as women and young children not otherwise eligible for Medicaid. Among employed individuals, Hawaii Health Director Jack Lewin (whose state-run hospital system is an NAPH member) has strongly urged that health reform not be phased in by size of employer, as that would lead to significant instability in the structure and cost of benefits between large and small employers. Among the employed uninsured, particular attention will need to be paid to dependents, part time employees, and seasonal and migrant employees, to prevent these populations from falling through the gaps.

C. It is also essential to recognize that, however noble the goal of universality, **there will always be coverage gaps** and individuals who fall through them. An institutional safety net, including hospitals, community health centers, and other providers, will need to remain in place (and be publicly financed) to serve these patients. Even Hawaii's much-touted health plan has gaps -- as is evidenced by the continued existence of a state-subsidized public hospital system.

D. In many cases, as our experience with Medicaid demonstrates, individuals who may otherwise be eligible -- especially in inner cities and isolated rural areas -- will simply not sign up for a new national health plan, even if mandatory. Rather, they will present themselves to providers in the future as they do today -- sick or injured, addicted or mentally ill, homeless, often unable to provide us with basic information about themselves. It is therefore imperative that (unlike Medicaid, AFDC and food stamps today) **the eligibility process should be kept as simple as possible**. As eligibility is phased in for various groups, providers must be able to rely on the presumptive eligibility of any individual who shows up in the emergency room.

E. It is important to understand that simply giving a patient a card will not ensure that his or her needs will be met. A dramatic recent indication of that fact occurred last year in Milwaukee, when well over 200 children were hospitalized (and several died) as a result of a measles epidemic that could have been prevented through simple immunizations. **Over two thirds of the children hospitalized were enrolled in Medicaid managed care plans!**

2. BENEFIT PACKAGE

A. A basic benefit package and "basic risk pool" should be developed, based on the mandatory federal Medicaid benefit package, but with a **greater emphasis on (and first dollar coverage for) primary and preventive care**. For cost containment purposes and so that it may be applicable to the widest possible population, the basic package should include catastrophic limits (in effect, a "stop loss") on hospitalization and high

tech providers and treatments.

B. To augment the basic package and basic risk pool, a parallel **"high risk" benefit package and risk pool** should also be developed, for individuals with more serious illnesses, injuries or conditions. The high risk package can provide for more utilization and provider controls and stricter case management requirements than the basic package. All insurers should be required to offer both packages, and indeed, switching from one risk pool to another should be essentially transparent to the insured.

C. As with eligibility, any system of health reform must acknowledge that there will be a number of services whose costs will continue (in whole or in part) to fall outside either benefit package. These services will range from costly 24-hour standby services such as trauma, burn care, and neonatal intensive care, to traditional public health and even non-health social services that are often needed by low income patients whether or not they have coverage. These safety net and community-wide services must continue to be provided and funded outside the health insurance system, through add-on community service payment adjustments or through direct grants or subsidies.

D. Alternative providers, such as nurse midwives and nurse practitioners, should be accommodated and encouraged wherever possible.

3. FINANCING HEALTH REFORM

A. NAPH strongly supports a broad array of financing mechanisms for universal health coverage, including taxes on excess employee health coverage, so-called "sin taxes" on alcohol and tobacco, sliding scale cost sharing for higher income insured individuals, and increased Medicare cost sharing. However, we would oppose the enactment of any such taxes solely to reduce the deficit; they should be dedicated to the extent possible to financing expanded health coverage.

B. NAPH also suggests that a number of other relevant taxes or fees be considered, such as an increased excise tax on guns (especially semi-automatic weapons), a hospital maintenance fee on unused or unstaffed beds or underutilized technology, or a tax or surcharge on "luxury" treatments or services.

C. NAPH agrees that cost containment must be an essential element of any national health plan, and would support cost containment methodologies that are applied equitably across all insurers and providers (rather than being limited only to public programs). To be effective, cost containment strategies must be administered locally, at the community level, and should not penalize efficient providers (but rather, should target underutilized or otherwise inefficient providers).

D. In recent years, the so-called "disproportionate share hospital" ("DSH") adjustments paid by Medicare and many Medicaid programs have been of particular importance in helping safety net hospitals make ends meet, assisting overburdened local governments in preserving and improving health safety net services. There has been some talk of using these adjustments as a "funding source" for national health reform. However, we believe it is essential that these adjustments be continued and strengthened until such time as other sources of funding are available AND FULLY PHASED IN for the presently uninsured.

E. We further believe that many residual community-wide public health and social services will continue to be needed even after most uninsured Americans have been provided some form of health coverage. Such services will range from emergency "standby" services such as trauma centers, burn centers, neonatal intensive care, and the like, to public health and social services that will still be needed by low income patients. For this reason, as part of health reform, NAPH is proposing the phase-in of a separate "Community Services Adjustment" that would be carefully targeted on safety net

hospitals and other facilities (such as community health centers) that will continue even under a new national health plan to provide these community-wide services.

4. PLAN ADMINISTRATION

A. NAPH supports the concept of managed competition in principal, and believes it should be given an opportunity to work wherever feasible. However, based on our extensive experience serving the urban uninsured, we are concerned that managed competition as described in the literature to date may be less effective in some areas, including inner cities and isolated rural areas. This is true for several reasons, including the dearth of a sufficient number and variety of providers to guarantee access and choice in those areas; the checkered history of efforts to introduce competitive models (such as the California PHP scandals of the early 1970s and the Florida scandals of the 1980s); and the nature of the patient population itself in such areas. NAPH is developing recommendations for alternatives or modifications to managed competition in major metropolitan areas.

B. It must be further recognized in implementing "managed competition" that the playing field is not currently level for either providers or patients -- especially in the inner cities and remote rural areas. To be equitable, and to guarantee access for patients in such areas to the broadest range of health and social services, a plan must ensure that all safety net providers (including health centers as well as public hospitals) are given an equal opportunity to develop and participate in competitive plans.

C. NAPH also cautiously endorses the concept of the HIPC as an intermediary for both the employed and unemployed uninsured, but with significant safeguards against abuses by insurers and others who may develop new plans in response to health reform. Of particular concern is the possibility of adverse selection and "targeted marketing" by some plans -- cream-skimming, if you will -- that will leave the sickest and the poorest to enroll in "public plans". NAPH will be developing a detailed list of possible safeguards, including mandatory open enrollment, limitations on advertising, and mandatory random assignment of "high risk" patients.

D. NAPH supports the broadest possible range of insurance industry reforms, including full portability, a ban on preexisting conditions, and community rating for all plans and all employers.

E. NAPH strongly supports the establishment of a National Health Board at the earliest possible opportunity. We believe this Board should be fully independent, with members confirmed by the Senate, and should have a broad range of powers. Included would be a transfer of all of the functions and personnel of the current Health Care Financing Administration (and responsibility for the Medicare and Medicaid programs), the definition and fine tuning of the basic and high risk benefit packages recommended above, the development of uniform reporting, accounting and claims processing standards, collecting and analyzing nationwide data, administering and certifying the HIPCs, quality and outcomes assessment, technology assessment, and measuring consumer satisfaction.

MEETING THE MORE IMMEDIATE NEEDS OF URBAN SAFETY NET HOSPITALS

Many supporters of various national health reform proposals have suggested that, if reforms were enacted, there would no longer be a need for an institutional health safety net. We can only note that the same thing was said about the enactment of Medicare and Medicaid. Given the strong likelihood that future changes will continue to be incremental and piecemeal, NAPH believes that there will continue to be a strong need for the public health safety net in our nation's metropolitan areas.

In particular, as the crisis last year in South Central Los Angeles clearly underscores, our current health safety net is extremely fragile and underfunded today. The health safety net, consisting largely of county facilities and programs, worked for Los Angeles during the riots. Reports tell of extraordinary heroism and dedication by County medical and administrative staff, especially at the Martin Luther King/Drew Medical Center, in the middle of the war zone. Safety net hospitals were flooded with hundreds of casualties -- without their standby readiness, the death toll would have been far higher than it was, and many of the injured would have been far worse off as well. But it was clear that the County system in Los Angeles was stretched to the very limit. And it was also clear that health insurance coverage alone would never have financed the full range of emergency system, trauma network, public health and social costs of meeting the community's needs during this crisis.

We must thus be extremely careful about dislodging any current institutional funding mechanisms for public health systems in general, and safety net hospitals in particular, unless we are certain that we have a workable and fully implemented system to take their place. Moreover, we must continue to press forward with more targeted programs and reforms that support "stand by" health and social services and safety net providers.

For many reasons, even if national health insurance were adopted this year, America's safety net institutions will need continued support well into the future:

- Any new health reform system is likely to be phased in over a long period of time.
- Even with coverage, many of our current uninsured will be little better off than Medicaid patients, who today find their access restricted in many states to those "open door" hospitals and clinics who will serve them.
- It is also important to recognize that many of the current uninsured also suffer from a variety of health and social problems very different from those of middle America -- AIDS, drug abuse, tuberculosis, and teenage pregnancies are often augmented by homelessness, joblessness, and lack of education; while no health care provider can fully cope with all of these problems, our urban safety net hospitals are the only ones even trying to do so today.
- In addition, we must recognize that even for insured individuals today, with the dramatic cost containment efforts already being imposed by both public and private payers, many expensive and unprofitable "standby" services (such as trauma, burn care, and neonatal intensive care) are also far more likely to be available in safety net hospitals.
- Finally, many safety net hospitals are simply located in the geographic areas where most of our uninsured Americans reside -- areas which, even if national health coverage were fully implemented, most other health care providers will continue to be unwilling or unable to serve.

For these reasons, this final section of my prepared testimony is intended to call your attention to a number of shorter term needs that must be met over the next several years, in support of the nation's safety net hospitals.

A NEW NATIONAL CAPITAL FINANCING INITIATIVE IS NEEDED TO REBUILD AND EQUIP AMERICA'S INSTITUTIONAL HEALTH SAFETY.

Safety net hospitals also face a substantial need for adequate capital to rebuild and equip our nation's health infrastructure. A new NAPH study estimates that there are at least \$15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. Our safety net health care infrastructure is every bit as important as those elements that are more commonly considered in public works bills.

(Indeed, several of our nation's inner city public hospitals were initially constructed using WPA labor and funds.) In order to meet these needs, a new Federal capital financing initiative is clearly needed. Last year, NAPH assisted with the drafting of a major new capital financing initiative that was introduced by Subcommittee Chairman Pete Stark in the House, and by Senators Thomas Daschle and John Breaux in the Senate. While its cost to the federal government would be only \$1 billion per year, this bill would create federal-state-local and public-private partnerships to finance up to \$15 billion in capital improvements for safety net hospitals, through loan guarantees, interest rate subsidies and grants to meet both general and specific safety net capital needs.

IN THE SHORT TERM, THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT MUST BE PRESERVED AND INCREASED.

Medicare is a relatively smaller proportion of the patient load in safety net hospitals than in the rest of the industry (only 18%, as compared to 34% on average for the industry as a whole). However, Medicare is usually the single most important non-indigent payor in many safety net hospitals, and as such, constitutes an essential part of patient care revenues.

Due largely to the efforts of your Subcommittee, great strides have been made in mandating Medicare payment adjustment increases for "disproportionate share hospitals." This program has grown from paying just \$200 million in its first year to well over \$1.5 billion in 1992. In the last three years, Congress has also refrained from making any further reductions in the indirect teaching adjustment. This has resulted for the first time in actual real dollar gains in Medicare reimbursement for safety net hospitals, although these gains have not succeeded in erasing the significant operating deficits of such hospitals (such deficits currently average over \$9 million, or 6%).

UNLESS AND UNTIL UNIVERSAL COVERAGE BECOMES A REALITY, CONTINUED EFFORTS MUST BE MADE TO IMPROVE AND REFORM THE MEDICAID PROGRAM.

While we know Medicaid is not within the jurisdiction of this Committee, for the sake of completeness (and because it is relevant to health reform) I want to briefly mention our concerns in this area as well. Recent improvements in the Medicaid program have expanded eligibility for pregnant women and children, permitted states to continue using a variety of mechanisms for providing extra payments to disproportionate share hospitals, and permitted public and private hospitals to participate in the financing of Medicaid expansions through voluntary donations and the transfer of funds by local governments to states. In addition, states like Florida, New York and New Jersey have used provider taxes, all-payer systems, or intergovernmental transfers to redistribute revenues and enhance Medicaid payments. It is imperative that states be permitted to continue to make use of these alternative sources of revenues, at a time when many are suffering severe budget crises. It is also imperative that local governments permit the pass-through of these increased Medicaid funds to the hospitals and health facilities actually providing the Medicaid and indigent care.

DIRECT INSTITUTIONAL OPERATING SUPPORT FOR SAFETY NET HOSPITALS MUST ALSO BECOME AN IMMEDIATE FEDERAL PRIORITY.

While Medicare clearly has a role to play in sharing the financial burden of safety net hospitals, it is also true that additional measures are needed. In particular, as the debate over universal health coverage drags on, it is imperative that the Congress enact some form of nationwide institutional support for safety net hospitals.

Ideally, this should take the form of a national uncompensated care trust fund, with dedicated sources of revenue. Legislation originally developed by Subcommittee Chairman Pete Stark, and introduced in the last Congress as H.R. 754, could serve as a model. That legislation would create a trust fund with the proceeds of a small tax on health insurance premiums; such a tax could generate potentially \$600 million to \$1 billion for distribution to high volume providers of uncompensated care. Other potential funding sources that have been mentioned

include taxes on alcohol, tobacco and firearms, as well as a national excise tax on hospital utilization.

TARGETED PUBLIC HEALTH PROGRAMS

Other targeted public health programs and resources that we are proposing or supporting include proposals to:

- improve the ability of public hospitals and other safety net institutions to train and employ minority health professionals and inner city residents;
- improve the ability of urban safety net providers to develop and finance regional provider networks that include a full range of services, including ambulatory and preventive care in addition to acute inpatient care, and to participate as effectively as possible in managed care programs and initiatives; and
- fund new services aimed at high risk populations, including drug-dependent mothers and babies, patients and providers in danger of contracting drug-resistant tuberculosis, prisoners, low-income children with chronic diseases such as asthma, and victims of domestic violence and child abuse.

I would be pleased to answer any questions you may have at this time.

ATTACHMENT TO TESTIMONY OF LARRY GAGE, PRESIDENT, NAPH

NAPH Principles for Health Reform (adopted in 1990)

- While incremental improvements are acceptable, the goal of any national health plan must be universal access or coverage for all.
- However, it must also be recognized that even under the most comprehensive national plan, there will always be individuals who fall through the cracks; NAPH believes it is both necessary and acceptable to provide access for such persons through the preservation of a strong and well-financed **institutional safety net**.
- A national health plan must require consistent, national eligibility, service and provider payment standards for the Medicaid program; serious consideration should be given to the federalization of Medicaid (together with its expansion to serve all of America's medically indigent) or its elimination and merger with Medicare.
- A core national minimum benefit package must be developed that is not so rich as to be unaffordable, yet covers essential preventive, primary care and hospital services, and guards against the burden of catastrophic illness.
- The present system of private insurance can continue under a national health plan, but insurance reform is an essential part of any national health package; the federal government should preempt state regulation to the extent necessary to set national standards for health insurance plans, which include mandating minimum benefit packages on all employers above a reasonable size, reinstatement of community rating, and curbing current trends toward exclusion of preexisting conditions (or setting post-illness limits on specific diseases such as AIDS).
- Any national plan must include a heavy emphasis on preventive and primary care and must provide adequate support for initiatives to encourage changes in lifestyles.
- And finally, states must be permitted wider latitude to experiment with new plans, including the ability to waive ERISA constraints on the regulation of self-insured businesses.

Results of the "Quick Start" Survey

National Association of Public Hospitals

December 21, 1992

NAME OF HOSPITAL	PROJECT DESCRIPTION	DOLLAR AMOUNT OF PROJECT (in millions)
Charity Hospital/Medical Center of Louisiana (New Orleans, LA)	● Expand outpatient capacity for OBs, Psychiatry, and HIV program	\$8.0
	● Adult and pediatric isolation capacity for TB/HIV program	\$3.2
	● Renovate Pittsburg Health Center to create women's primary care health center	\$0.8
	● Purchase new primary care clinic space and relocate the Brentwood Health Center and expand primary care to an underserved population	\$0.8
Contra Costa County Health Services Department (Martinez, CA)	● Create 16 additional primary care exam rooms at Pittsburg Health Center	\$0.8
	● Purchase primary care clinic space in Antioch and expand primary care service by 1,000 visits per month	\$0.3
	● Relocate Older Adults' Clinic from Concord to Pleasant Hill	\$0.35
	● Renovate concord space to expand primary care services	\$0.05
Cook County Hospital (Chicago, IL)	● Construction of freestanding diagnostic and therapeutic treatment center for AIDS/HIV Care. Currently, Cook County is providing 12,000 o/p visits in 3600 sq. ft. Conversely, Harris County in Texas is providing 16,000 o/p visits in 36,000 sq. ft.	\$3.0
	● Construction of diagnostic and therapeutic radiology center. Hospital requires 2 MRIs, 2 additional CTs to appropriately manage current volume. Replacement of current cobalt units with modern linear accelerators is required.	\$13.5
	● Renovation of antiquated labor and delivery areas which currently offer no auditory and limited visual privacy as patients are separated by curtains. Cook County delivers in excess of 4,000 babies annually.	\$10.0
	● Ambulatory Care Center Building - This would house all Denver Health & Hospital subspecialty clinics and the primary care clinic for the area near the hospital.	\$13.5
Denver Dept. of Health & Hospitals (Denver, CO)	● Park Hill Health Station - The current leased space does not meet code and must be replaced.	\$1.7
	● Public Health Building - replacement of electrical and ventilation system to facilitate care of HIV, TB, and AIDS patients.	\$3.0

NAME OF HOSPITAL	PROJECT DESCRIPTION	DOLLAR AMOUNT OF PROJECT (in millions)
Hennepin County Medical Center (Minneapolis, MN)	● Pilot City Health Center reconstruction project. Construction begins approximately May 1993. Pilot City Health Center sees approximately 45,000 patient visits/year. ● Hennepin Care North. New clinic in first ring suburbs for medically underserved clients. Remodeling is in an existing facility. Construction to begin February 1993. Expected patient visits 20,000/year. ● Hennepin Care West. New clinic for western suburbs. Expected start 1994.	\$8.3 \$1.2 \$2.0
High Desert Hospital (Lancaster, CA)	● Perinatal Center at new hospital site. ● Primary Care Building - new hospital site. ● Urgent Care Center ● Rehabilitation Services Expansion ● Emergency Room at existing hospital ● Health Education Building ● Infrastructure Improvements - new hospital site	\$37.0 \$12.0 \$7.5 \$18.3 \$1.8 \$4.6 \$12.0
Highland General Hospital (Oakland, CA)	● Upgrading inpatient units to TB Units ● Adolescent Subacute Psychiatric Building ● Comprehensive County Wide Data Information System	\$1.2 \$5.5 \$2.0
Hurley Medical Center (Flint, MI)	● Women & Children Ambulatory Clinic - On campus expansion of medical office building for the OB/Gyn and pediatric clinics which service predominantly Medicaid population, in excess of 28,000 visits a year. ● Physician Office Building - An off-site office building for a core group of seven black primary care physicians who provide a great deal of care for a portion of the city's population, for which access to the healthcare delivery system is problematic. ● Beecher Clinic - a clinic recently shut down due to financial difficulties that serves a large indigent population.	\$3.2 \$1.35 Undetermined

NAME OF HOSPITAL	PROJECT DESCRIPTION	DOLLAR AMOUNT OF PROJECT (in millions)
LAC+USC Medical Center (Los Angeles, CA)	● TB Control - ward upgrade to include Air Conditioning ● High Risk Unit - Outpatient clinic specializing in high risk health problems associated with infants ● ICU Upgrades - 3 ICU's need to be upgraded; utilities, medical gases, air conditioning and patient monitoring ● Ambulatory Care Building for Primary Care ● Air Conditioning for Wards in Psychiatric Hospital	\$2.0 \$0.5 \$1.2 \$7.0 \$7.0
	● Trailer (30,000 square ft.) for use as clinic space in which to provide primary care services to adults, adolescents and children. ● Trailer (15,000 square ft.) for use as a training facility for Allied Healthcare professionals to meet the needs of expanded primary care services. Potential joint venture with affiliating University. ● Trailer (15,000 square ft.) for use as a patient education center in conjunction with expanded primary care services.	\$6.0 \$2.3 \$2.3
	● Outpatient services center	\$3.0
	● Various managed care, off-site clinics ● Various communicate, off-site clinics	\$9.5 \$5.0
	● Tuberculosis Management - Upgrade ventilation system throughout the facility to accommodate air changes, filtration and exhaust to prevent nosocomial infection.	\$1.29
NYCHHC/Kings County Hospital Center (Brooklyn, NY)	● Tuberculosis Management - Renovate med-surg unit to create 21 code compliant isolation rooms with proper ventilation, anteroom and hall	\$1.65
	● HIV Clinic - To meet increased demand, expand current clinic from 6 room examination suite to 12 room with offices.	\$0.09
	● Tuberculosis Management - Upgrade HVAC system in AIDS treatment, methadone and diagnostic clinics and morgue for improved environmental control.	\$3.29
NYCHHC/Elmhurst Hospital (Flushing, NY)	● Neonatal Renovation and Expansion - Relocate and expand current 19-bed neonatal unit to a 27-bed unit to meet increased demand in the community.	\$3.35

NAME OF HOSPITAL	PROJECT DESCRIPTION	DOLLAR AMOUNT OF PROJECT (in millions)
NYCHHC/Bellevue Hospital Center (New York, NY)	●Tuberculosis Management - Upgrade ventilation in the chest unit and create 14 code compliant isolation rooms for TB patients.	\$1.8
NYCHHC/Bronx Municipal Hospital Center (Bronx, NY)	●Tuberculosis Management - Convert 8 patient rooms into code compliant isolation rooms with appropriate ventilation, anteroom and bath.	\$0.29
NYCHHC/Harlem Hospital Center (New York, NY)	●Offsite relocation of the outpatient adolescent psychiatric department.	\$1.0
NYCHHC/Cumberland Diagnostic and Treatment Center (Freestanding community health center) (New York, NY)	●Expand dental care unit to allow for complete treatment.	\$0.11
NYCHHC/Gouverneur (Freestanding community health center) (New York, NY)	●Birthing center expansion	\$0.65
NYCHHC/Coney Island Hospital (New York, NY)	●TB Isolation area ventilation ●Managed Care Program - on-site and off-site	\$1.0
Olive View - UCLA Medical Center (Sylmar, CA)	●Ambulatory Care Center - Primary care services provided by Pediatrics, General Internal Medicine, Family Medicine, OB/GYN. ●Education Center - Auditorium, classrooms, library, lounge, for educational programs aimed at hard to recruit personnel needs and at prompting employment and career development for minority and disadvantaged populations. ●Utility and Roadway System Repair - Replacement of 1920's era obsolete and hazardous utilities and repair of earthquake damaged roads and utilities.	\$3.5 \$7.0 \$3.2
Parkland Memorial Hospital (Dallas, TX)	●Community Oriented Primary Care (COPC) Site, Garland, Texas ●COPC site, Northwest Oakcliff, Dallas, Texas ●Renovation of Pediatric Wards (2 million), creation of Epilepsy Unit (1 million), renovation of operating rooms (2 million)	\$2.0 \$3.0 \$4.5 \$5.0

NAME OF HOSPITAL	PROJECT DESCRIPTION	DOLLAR AMOUNT OF PROJECT (in millions)
Rancho Los Amigos Medical Center (Downey, CA)	● Allied Health Therapy Clinic - Remodel a section of the Medical Center to develop outpatient therapy areas for Physical Therapy, Occupational Therapy, Speech and Audiology Clinics.	\$4.5
	● Urology Clinic - Expand the Urology Clinic by enlarging the waiting area and add examination rooms.	\$2.5
	● Medical Imaging Waiting Room - Patients currently wait in the hallways. This project calls for adding on to the existing building to provide for a waiting area for gurneys and wheelchairs.	\$1.0
	● Conversion of air handling system, equipment, etc. to convert beds to TB standards.	\$0.10
Regional Medical Center at Memphis (Memphis, TN)	● Labor and delivery service area renovations and area support for prenatal care.	\$3.0
	● Ambulatory care center completion, phase two patient education and diagnostic support areas.	\$3.0
Riverside County Health Service Agency (Riverside, CA)	● Riverside Neighborhood Health Center - Primary and urgent care facility will include perinatal, family planning, immunizations and disease control (including TB) services. Located in redevelopment project area.	\$4.0
	● Satellite Desert Health Center - Primary and urgent care designed to improve access for underserved desert residents.	Est. \$3.0
	● Remodel/expand Banning Health Center - Current space too small to meet increased demands.	\$0.54
San Bernardino Medical Center (San Bernardino County Medical Center)	● New Family Health Center to be located in Cocton, CA	\$1.8

NAME OF HOSPITAL	PROJECT DESCRIPTION	DOLLAR AMOUNT OF PROJECT (in millions)
San Francisco General Hospital (San Francisco, CA)	● TB Precaution Improvements in Existing Clinic and Inpatient Space: The SFGH patient population is at high risk for multi-resistant TB, and SFGH urgently needs to remodel inpatient rooms to correct airflow, and protect health care providers and other patients from exposure to TB. In outpatient clinic treatment and waiting rooms, the project will improve air handling and install HEPA filtration system to minimize exposure of staff and other patients to TB.	\$1.6
	● Computer Systems Foundation for Managed Care: Managed care will require efficient access to patient records/data across systems that exist today. The first step in achieving that is the development of the "backbone" system to connect computers/applications via cable or fiberoptic network. This project will connect all existing patient care areas and key administrative areas on the AFGH campus. It does not include the network application software or new computer systems.	\$2.0
	● Ambulatory Care Center: Delivery of surgical services continues to move rapidly in the direction of ambulatory patients and minimally invasive technology. The Operating Rooms and support areas at SFGH were designed in an era thoroughly dominated by inpatient surgical services, and the layout does not allow for efficient management of same day and ambulatory patients, including intake, waiting, post procedure recovery, patient education, etc.	\$2.0
Santa Clara Valley Medical Center (San Jose, CA)	● Outpatient Facilities Life Safety: The AFGH Medical Center Campus has 11 buildings, 10 of which predate 1920 and have had no significant renovation since construction. These facilities are in heavy daily use for outpatient services and patient support functions such as eligibility and registration. The facilities need extensive renovation to meet minimal life safety and access requirements.	\$20.0
	● Relocate AKU/Dialysis	\$0.5
	● Relocate East Valley Clinic (50,000 visits/yr - primary care)	\$5.0
	● Build Additional Satellite Clinic	\$5.0

NAME OF HOSPITAL	PROJECT DESCRIPTION	DOLLAR AMOUNT OF PROJECT (in millions)
Stanislaus Medical Center (Modesto, CA)	• 30,000 square foot women and children's outpatient building that combines Public Health, Mental Health and medical services for the low income or patients without access to physicians. • Skilled Nursing/sub-acute facility to provide services for both mental health and acute-care patients no longer needed hospitalization. • 14,000 square foot outpatient building to house dental, pediatrics, industrial health and wellness programs. Many of these programs geared to prevention and education.	\$11.2
	• Link existing primary care centers, public hospital, city/county health dept., school dist., Kellogg Grant project and human service dept. into a collaborative provider for computerized record keeping network, additional primary care personnel, additional sites along approx 22 miles of U.S./Mexican border to serve 200,000 + persons at or below poverty level.	\$10.0
	• Expanded Primary Care Ambulatory Area	\$2.0
	• Hepatitis B Virus Immunization Program • Immunization Action Plan • Primary Medical Care Transportation Service	\$0.05 \$0.02 5 \$0.02
Valley Medical Center of Fresno (Fresno, CA)	• Primary Care Clinics • Birthing Center	\$2.0 \$1.0

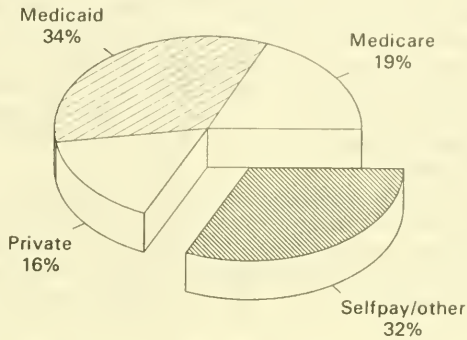
TOTAL AMOUNT OF PROJECTS: \$334,424,000

TOTAL NUMBER OF NAPH MEMBERS: 100

TOTAL NUMBER OF HOSPITALS RESPONDING: 33

Total Gross Revenues for NAPH Member Hospitals By Payer Mix for 1990

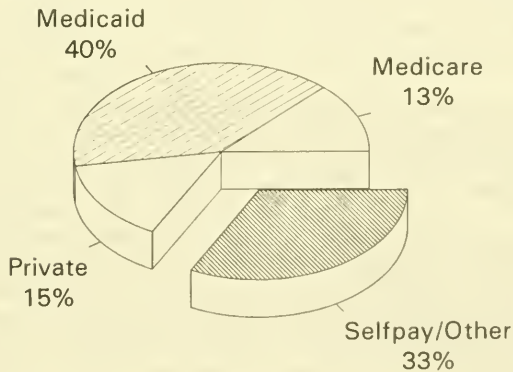
65 Hospitals Responding



Gross Revenues = \$14.4 Billion

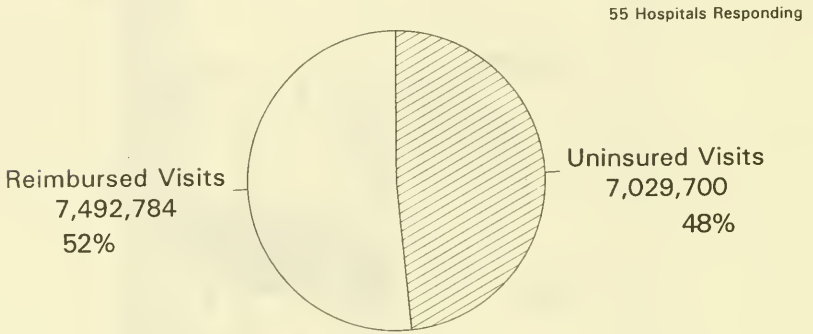
Discharges by Payer Source for NAPH Member Hospitals, 1990

No. Hospitals Responding: 65



Total Discharges = 1,339,967

Uninsured Visits as a Percentage of the Total Outpatient Utilization, 1990



Total Visits = 14,522,483

Mr. LEVIN. Thank you very much.

Dr. Foreman.

STATEMENT OF SPENCER FOREMAN, M.D., CHAIRMAN, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND PRESIDENT, MONTEFIORE MEDICAL CENTER, BRONX, N.Y.

Dr. FOREMAN. Good morning, Mr. Chairman. I am Dr. Spencer Foreman, president of Montefiore Medical Center in the Bronx, and the chairman of the Association of American Medical Colleges.

I will focus my remarks this morning on summarizing my written testimony, which itself concentrates on three areas of the administration's proposals: the reduction of indirect medical education (IME) payments, the changes in direct graduate medical education payments (DGME), and the reductions in hospital outpatient payments.

Underlying the proposal to reduce indirect medical education payments is the belief that the shortcomings in the PPS system for which these payments were originally designed are gradually being addressed by refinements in other elements of the Medicare prospective payment system (PPS), and, therefore, continuing payment at the current level is unjustified.

I would submit that the indirect medical education payments were never designed as a precise tool. Unlike DME, they were not based on specific costs. IME was at the outset, and is now, a surrogate intended to compensate for the inadequacies of PPS to account fully for such things as severity of illness. More recently, it has been used by Congress to stabilize teaching hospitals financially by assuring them that their total margins remain roughly comparable to those of nonteaching hospitals.

While teaching hospitals have had PPS margins somewhat larger than nonteaching hospitals, as we heard this morning, their total margins have been consistently substantially less than nonteaching hospitals. Of great concern to us is that in 1992 our data indicate that the PPS margins in academic medical center hospitals dropped dramatically, from slightly less than 6 percent in 1990 to less than 4 percent in 1992.

If IME were cut as proposed, the PPS margins would plunge for these hospitals, and the total margins would fall through the floor. Some \$1.9 billion is being proposed to be removed from the system through this mechanism by the year 1997. This would cost Montefiore Medical Center \$9 million a year.

I did a quick calculation based on Dr. Altman's testimony. If we adopted the ProPAC recommendation, the aggregate cuts for the system if we reduced IME to 7 percent instead of 5.6 percent would be on the order of magnitude of a half a billion dollars, and our institution would suffer about \$2.5 million of that cut. There is little doubt that reductions of this magnitude would do us and the system considerable harm.

Now, the proposal to reduce the direct medical education payments has a very different rationale. Its critics contend that there are large, unjustified variations in payment among teaching hospitals, and that the present payment system encourages the training of the wrong kind of doctors. Unlike IME, there is a historical cost basis for DGME payments. These costs include salaries and

benefits for both residents and supervising physicians, and such other kinds of costs such as supplies, clerical support, teaching space, and certain allocated overhead.

Variations in DME costs exist because each teaching hospital relies on multiple funding streams to support their educational programs. These funding streams differ at each institution and include: faculty earnings, a portion of which are derived from Medicare part B; State appropriations; funding from the Veterans' Administration; appropriations from municipal governments; gifts and grants; and, finally, Medicare part A, or hospital payments.

The proportion received from each funding source tends to vary from institution to institution. Inner-city hospitals with limited faculty practice income or hospitals with no State subsidies tend to have much greater reliance on part A payments. However the funding source is derived, the costs of graduate medical education have to be paid. It is not as though some institutions have found a cheap way of providing a quality education.

In institutions with low part A costs, the education is being subsidized by other income streams. Averaging part A payment will have its greatest effect on those institutions for whom part A has been the principal funding source. Many of these serve vulnerable inner-city populations. Some are simply small hospitals with small training programs. In many areas, particularly in New York City, the major teaching hospitals will be severely hurt.

As Mr. Raske from the Greater New York Hospital Association will point out later, the State of New York stands to bear the burden of accepting \$200 million of the \$350 million anticipated savings, and Montefiore would lose \$14 million per year.

With respect to the argument regarding creating the wrong kind of specialists, the Association of American Medical Colleges agrees that we are producing far too few generalists and too many specialists, and it is committed to reversing that trend.

We believe, however, that the principal barriers to the selection of primary care residencies is the perception by graduating medical students that primary care is an unattractive professional role. It is not the unavailability or the inadequacy of training opportunities. There are already many more primary care residency positions than applicants, and there is no evidence that available positions go unfilled because they are unattractive or of low quality.

Therefore, increasing the payments to hospitals to encourage them to increase the number of positions or improve their quality we believe is not likely to work. Moving to the proposed weighted system will simply reduce the total DGME outlay as primary care positions remain unfilled. That will save Medicare money, but will severely damage many teaching hospitals.

With respect to outpatient payments, unlike the reduction of IME and DGME, there seems to be no philosophical underpinning for proposing reductions in outpatient payments. It is simply a matter of saving money. Hospital-based outpatient clinics are very important sources of care. Their costs tend to reflect the severity and complexity of illnesses among the poor and the inefficiencies resulting from patients who appear at the hospital site on an episodic basis and thus receive discontinuous care in a teaching setting. We believe that prospective payment has been shown to be a

better approach to controlling outpatient clinic costs, and we recommend it.

That concludes the remarks I was prepared to make, but with your permission I would just like to accept your invitation to comment on something that Dr. Altman said in his testimony with respect to cost shifting.

Cost shifting requires two sets of facts to work. First, it must be permitted by law. In New York State, it is not permitted by law. Rates are under the control of the State government, and, therefore, it is impossible to transfer costs that are removed from Medicare to any other payer.

The second requirement is that there needs to be someone to accept the costs that are shifted. That requires two things: that there be able payers, that is, a group of payers whose resources give them the capacity to accept higher costs; and willing payers, a group that will accept those costs and simply pay them.

In very many hospitals around the country, particularly teaching hospitals, the number of able payers is shrinking and in the inner-city hospitals already do not exist, and the number of willing payers are disappearing as well, as rates are negotiated with hospitals and health systems. Therefore, I believe that a transfer of Medicare's obligation to another payer sector is not likely to work, and the cuts levied on the institutions are more than likely to be borne by the institutions themselves.

Thank you, Mr. Chairman.

[The prepared statement follows:]

**STATEMENT OF SPENCER FOREMAN, M.D.,
PRESIDENT, MONTEFIORE MEDICAL CENTER, BRONX, N.Y.,
AND CHAIRMAN, ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

Mr. Chairman and members of the subcommittee, I am pleased to appear before you to discuss the administration's Medicare budget proposals with respect to hospital payments. I am Spencer Foreman, M.D., chairman of the Association of American Medical Colleges (AAMC) and president of the Montefiore Medical Center in Bronx, New York. The AAMC represents all of the nation's medical schools, 92 faculty societies, over 350 major teaching hospitals that participate in the Medicare program, and over 140,000 men and women in medical training as students and residents. In 1992, nonfederal members of the AAMC's Council of Teaching Hospitals (COTH) accounted for nearly 2 million Medicare inpatient discharges.

All of the administration's health care budget proposals are of concern to the nation's teaching hospitals. This morning, however, I would like to address three specific Medicare proposals that are of particular concern to teaching hospitals. As outlined in the President's budget document, *A Vision of Change for America* (February 17, 1993), they are the:

- proposed gradual reduction in the indirect medical education (IME) adjustment in the inpatient prospective payment system (PPS), from its current 7.7 percent to 5.65 percent for each 0.1 increase in the intern and resident-to-bed ratio (IRB);
- proposed changes in payments for direct graduate medical education (DGME) costs that would base these payments on a national per resident amount derived solely from the average of salaries paid to residents, and would weight them based on the specialty area of the trainee and the length of the residency; and
- proposed reductions in hospital outpatient payments that extend the OBRA 1990 provision of reducing the reasonable cost portion of the payment by 5.8 percent, imposing an additional reduction of 4.2 percent on these services, and extending the 10 percent reduction in payments for outpatient capital costs.

Montefiore depends heavily on these payments for its financial viability. The medical center is the single largest provider of inpatient acute care to the 1.2 million residents of the Bronx, the poorest borough in New York City. The hospital has 1,256 licensed inpatient beds providing care to 15 percent of the Bronx residents and 30 percent of the borough's tertiary care services. The medical center also is the major teaching hospital for the Albert Einstein College of Medicine and supports the educational and research environments necessary to train more than 650 residents to serve future generations and to advance medical knowledge. Service to a large Medicare population and the size of its teaching program qualifies Montefiore for substantial IME and DGME payments. Any reduction in these payments would severely harm Montefiore's ability to sustain its education, research and patient care missions.

While the academic medical community understands the need and the commitment by the administration and the Congress to reduce the Federal budget deficit and the growth in Medicare expenditures, teaching hospitals would be particularly harmed by these proposed reductions. The Medicare proposals reducing payments to providers would reduce Federal spending by approximately \$28 billion over four years. While many of these proposals would affect both teaching and nonteaching hospitals, the proposed reductions in IME and DGME payments account for nearly \$3.3 billion, over 10 percent of the total planned cuts. The proposed outpatient payment reductions would further reduce Medicare payments by an approximately \$1.2 billion.

I shall focus my testimony on the three proposed reductions, which if implemented would seriously threaten teaching hospitals' financial stability, access to care for large segments of the population and the quality of care received by Medicare beneficiaries and other patients. Teaching hospitals are a critical component in our health care delivery system, and they could be easily damaged unless changes are crafted carefully and are based on an extensive understanding of the multiple missions of teaching hospitals.

Indirect Medical Education Adjustment

Since the inception of the prospective payment system, Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented their Medicare inpatient payments with the IME adjustment in the PPS. Unfortunately, the IME adjustment is mislabeled and frequently misunderstood. While its label has led many to believe

this adjustment to the DRG payments compensates teaching hospitals solely for graduate medical education, its purpose is much broader. Both the House Ways and Means and the Senate Finance Committees specifically identified the rationale behind the adjustment:

This adjustment is provided in light of doubts... about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents... The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, No. 98-25, March 4, 1983 and Senate Finance Committee Report, No. 98-23, March 11, 1983).

Some policy makers have maintained that a significant portion of the IME adjustment is intended to help defray uncompensated care costs. Further, they argue, in a reformed health care system where more individuals are covered by health insurance, teaching hospitals' burden of uncompensated care would be reduced and would justify a significant reduction in IME payments.

The AAMC has noted repeatedly the purpose of the IME adjustment is not to provide financing for uncompensated care, but to recognize factors that increase costs in teaching hospitals. Analysis by government and private researchers consistently has shown an empirical basis for a differential payment to teaching hospitals based on their costs. The justification for a special adjustment for these institutions traces back to the Medicare routine cost limits of the late 1970s and the inception of the PPS in 1983. Even if the health care system is reformed to improve access, legitimate cost differences between teaching and nonteaching hospitals will continue to exist. Teaching hospitals continue to have higher inpatient operating costs because of the types of patients they treat, comprehensive and intensive services they offer, and residents that are in training.

In recent years, Congress has indicated the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, the Prospective Payment Assessment Commission (ProPAC) has recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care, and has tried to assure "rough justice" among hospital groups. "Rough justice" refers to a policy objective of maintaining the overall financial viability of teaching hospitals as measured by total margins.

In making its recommendation to decrease the level of the IME adjustment to 7.0 percent for FY 1994, the ProPAC has urged caution in implementing a precipitous drop in the IME adjustment. While teaching hospitals' PPS inpatient operating margins are on average higher than those of nonteaching hospitals, teaching hospitals' total margins have remained consistently lower than PPS margins. ProPAC analysis of data from the eighth-year of PPS (1991), the most recent information publicly available, show average PPS margins for all hospitals have reached a new low of -3.2 percent while hospitals that received both IME and disproportionate share (DSH) payments posted PPS operating margins of about 5 percent. However, their average total margin was 3.4 percent compared with an average total margin for all hospitals 4.2 percent. Hospitals that received only DSH payments had the highest total margins of any group at 5.6 percent. (Presented Orally at ProPAC Public Meeting, Dec 11-12, 1992.)

Teaching institutions are vital national and community resources, often taking care of the most disadvantaged members of society. Yet their overall financial viability, on average, tends to be more precarious than nonteaching hospitals. Any reduction in the IME adjustment would further harm their financial position. In October 1992 the AAMC collected FY 1992 financial data from its members and shared the results with commissioners of ProPAC in a letter dated December 10, 1992. Data from 51 academic medical center hospitals showed PPS operating margins dropped dramatically in 1992, falling from an average PPS margin of 5.9 percent in 1990 to 3.8 percent in 1992.

As proposed, the reduction in the IME adjustment for all teaching hospitals would save \$1.9 billion over four years, beginning in FY 1996. In an analysis utilizing the administration's proposed payment level of 5.65 percent, AAMC staff have estimated that if the IME adjustment

were reduced to this level the average PPS operating margin for these 51 academic medical center hospitals would decrease to -3.0 percent. (See attachment A.)

This table also demonstrates that teaching hospitals depend heavily on the IME and DSH payments to maintain their PPS margins. On average, PPS margins calculated without the IME or DSH payment adjustments, that is, including only DRG, outlier, and "high End Stage Renal Disease (ESRD) use" payments, are -52.0 percent. The IME adjustment makes a significant contribution to decreasing the average negative PPS margin from -52.0 to -9.4 percent. The addition of the DSH payment to the margin calculation moves the average PPS margin to 3.8 percent.

The approximately 550 hospitals that received only IME payments and no DSH payment would be particularly harmed by a reduction in the IME adjustment. According to the ProPAC, these institutions had average PPS margins of -2.7 percent in PPS-8. Their total margins, while higher than the hospitals that received both IME and DSH payments, were lower than the hospital group that did not receive any IME or DSH payment and the group that received only DSH payments.

The IME payment is an important equity factor in the Medicare PPS, compensating teaching hospitals for the severity of their patients' illnesses, the scope of services provided, and the impact of educational programs on hospital operating costs. AAMC data for federal fiscal year 1991 show that IME payments account for 24 percent of total PPS payments. A reduction in the IME adjustment would hinder teaching hospitals' future capability to support adverse selection within the DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units. The AAMC urges the Congress to consider carefully the impact of any reduction in the IME adjustment on the financial stability of the nation's teaching hospitals and their ability to assure access to quality care for Medicare beneficiaries and other patients.

Direct Graduate Medical Education Payments

Our present system for graduate medical education and its financing has much to commend it. However, the system needs to change. The Association recognizes the present system has failed to produce the number of generalist physicians that society believes it will need in a reformed health care system. To that end, the AAMC has committed itself to identifying ways to reverse the significant underrepresentation of generalist physicians among practitioners in the United States. A recent Association policy statement calls for:

an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The policy document identifies and recommends strategies for the Association, schools of medicine, graduate medical education programs and the practice environment to facilitate reaching the goal. Its foundation rests on the implementation of voluntary, private sector initiatives. Among them is creating and maintaining incentive programs aimed at individual medical students, resident trainees, and practicing physicians as the preferred methods of inducing career choices in certain specialties.

We may all agree that the shortage of generalist physicians is unacceptable to society. The Association's policy statement on the generalist physician strongly endorses that private sector organizations and governmental bodies should join together in a partnership to eliminate the many barriers that exist to meeting the need for more generalist physicians. First among these strategies is reducing the marked disparity in income expectations resulting from our current system of physician payment. A second strategy is the development of appropriate training experiences in ambulatory, community-based non-hospital settings. As hospitals encourage shorter stays by more acutely ill patients, training in ambulatory and long-term care settings is needed to supplement the educational experience provided in hospitals to assure that residents receive comprehensive clinical training. The AAMC policy statement recommends:

- The Medicare program and other third-party payers should accelerate the

transition to a resource-based fee schedule and should adopt other reforms in physician payment designed to compensate generalist physicians more equitably.

- Mechanisms employed to finance the direct costs of graduate medical education should not create nor perpetuate barriers to shifting the balance between generalist and non-generalist training.

Some changes in direct GME funding will almost certainly be required to encourage residency training in non-hospital sites and to provide the resources for other initiatives designed to make the generalist specialties more attractive to medical students. However, the AAMC is not convinced that weighting Medicare hospital payments for graduate medical education by specialty will have a positive effect on the decisions senior medical students make with respect to specialty choice. Before proceeding directly to the debate on this issue, I shall provide some background on graduate medical education and its current method of financing.

The Environment for Graduate Medical Education

The nature of graduate medical education is changing. Many factors in the current environment are contributing to changes in how graduate medical education is conducted and how it may be financed in the future. Residency and fellowship education is a system of learning by participation in the care of individual patients and, therefore, includes elements of both education and service. However, as hospitals increasingly are called on to improve efficiency, residency programs are under constant pressure to emphasize service over their educational role. Additionally, while graduate medical education is organized primarily in hospitals and has been focused mainly on inpatients, its involvement with ambulatory patients is increasing.

Residency programs require long-term, stable funding commitments to provide an appropriate education and to enhance the quality of patient services. Graduate medical education has been funded primarily by patient service revenues to hospitals, with significant appropriations supporting some municipal- and state-supported hospitals and all military and Veterans Affairs (VA) hospitals. AAMC data show that, on average, hospital patient revenues supported 85 percent of resident stipends and benefits and 58 percent of clinical fellow stipends and benefits, excluding VA hospitals in 1991-92. (See Attachment B.) If anything, these data overstate the role of the hospital in financing graduate medical education, particularly for subspecialty clinical fellows, who are often not funded by the hospital, and therefore may not be included in the institution's records.

Faced with pressure to restrain health care expenditures, public and private third-party payers are adopting payment systems that limit or even decline to provide payments for graduate medical education costs. The costs associated with the training of physicians may not be recognized by payers as they shift to fixed price systems for defined "bundles" or packages of services, capitated payments, and negotiated contracts for selected services.

The Medicare Program's Role in Graduate Medical Education Financing

To provide experientially-based clinical training for physicians, dentists, nurses, and allied health professionals, hospitals incur educational costs related to patient care. For graduate medical education, these added costs include resident stipends and benefits, salaries and benefits for faculty who supervise residents in the care of patients, classroom space, supplies, clerical support, and allocated overhead. The Medicare program makes an explicit payment to teaching hospitals for its share of allowable direct graduate medical education and other health professions education costs. This payment is separate from, and should not be confused with, the purpose or methodology of the IME adjustment in the Medicare PPS. Historically, Medicare has shared in the direct costs of approved education activities on a reasonable cost basis.

The passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (P.L. 99-272) in 1986 changed the method of payment for direct graduate medical education costs and placed limitations on Medicare reimbursement for physicians in graduate medical training (residents). COBRA replaced a cost pass-through methodology with a prospective amount for each resident. The calculation of a hospital-specific per resident amount is based on the 1984 or 1985 cost reporting year (called the base year per resident amount) and is updated annually by an inflation factor. Each hospital's per resident amount is determined by dividing its allowable base year

costs by the number of full-time equivalent (FTE) interns and residents at the hospital during that base year. The per resident amount is then updated for inflation and multiplied by the number of FTE interns and residents in the hospital complex during the payment period. Residents are weighted at 1.0 FTE for the residency period required for initial board certification plus one year, not to exceed a total of five years. Beyond the lesser of these two limits, residents who remain in approved programs are to be weighted at 0.5 FTE. Medicare's share of the aggregate payment amount is based on the ratio of Medicare inpatient days to total inpatient days.

This change in payment methodology, which the AAMC did not oppose, terminated the previous open-ended commitment to financing graduate medical education. Although COBRA limits direct GME payments, it still acknowledges the historical scope of direct medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

The Administration's Proposal to Change Medicare Payments for Direct GME Costs

This year, the administration has proposed changes in Medicare payments for GME costs that are intended to provide incentives to encourage the training of generalist physicians and to eliminate the variation in the hospital-specific per resident amount. Additionally, this proposal would reduce the Medicare program's role in GME funding. This recommendation, which is similar to proposals made by the previous administration would save \$1.4 billion over four years by basing:

...Medicare DGME payments on a national per resident amount derived solely from the average of salaries paid to residents. Direct medical education payments would reflect differential weighting of the national average resident's salary, based on the specialty area a resident is pursuing and the length of the residency. A resident in a primary care specialty would be weighted at 240 percent, a non-primary care resident in the initial residency period would be weighted at 140 percent, and a non-primary care resident beyond the initial residency period would be weighted at 100 percent. The average weight would be 175 percent of the national average resident's salary, down from the average weight of about 215 percent under current law.

If adopted, this proposal would replace the current Medicare payment methodology for direct GME costs with a system based on three national rates. Thus, a hospital's total direct GME payment would be based not on its costs, but on the specialty mix of its trainees. The administration believes this proposal will not only eliminate the variation in direct GME payments, but also is intended to offer incentives to produce more primary care physicians. The proposal would accomplish this by paying relatively favorable amounts for primary care residencies, and substantially less favorable payment amounts for all other residencies. The administration's proposal does not define primary care residency programs and it does not indicate the national average resident's salary.

To estimate the impact of the administration's proposal on the AAMC membership, we assume that the national average resident's salary is \$31,795. This is the 1992-93 (FY 1993) average salary/stipend for the 3rd post-MD year based on the AAMC Council of Teaching Hospitals' (COTH) Survey of Housestaff Stipends, Benefits and Funding, 1992. Three differential weighting percentages would then be applied to this amount (\$31,795) depending on the resident's specialty:

- primary care residents would be weighted at 240 percent of the national average resident salary

$$\$31,795 \times 240\% = \$76,308$$
- non-primary care residents in their initial residency period would be weighted at 140 percent

$$\$31,795 \times 140\% = \$44,513$$
- non-primary care residents beyond the initial residency period would be weighted at 100 percent

$$\$31,795 \times 100\% = \$31,795$$

Medicare's share of the aggregate payment amount is then based on the hospital's ratio of Medicare inpatient days to total inpatient days. The effect of this differential payment method is that the scope of direct graduate medical education costs for trainees in all specialties will not be fully recognized particularly for non-primary care residents beyond the initial residency period.

This proposal would have a negative effect on most hospitals' Medicare payments for direct graduate medical education costs, depending on the hospital's specialty mix of resident trainees. According to data on the audited and updated per resident payment amounts provided by the Health Care Financing Administration (HCFA) and calculated by the AAMC, the median per resident amount in 1991 was \$48,804 (based on 1,214 providers). Under the administration's proposal, the Medicare program would pay significantly lower per resident amounts for non-primary care residents beyond the initial residency period (\$31,795 in 1993) and for non-primary care residents in their initial residency period (\$44,513 in 1993).

Although the AAMC strongly supports more individuals entering generalist practice, the Association does not believe this proposal would achieve its intended objective of encouraging the training of more generalist physicians. The Association opposes proposals that intend to stimulate the production of generalist physicians by weighting direct GME payments by specialty and length of training. There is no evidence that medical students' selection of residency training programs is related to Medicare payments to hospitals and there is no evidence that teaching hospitals will change the distribution of residency positions based on this incentive.

In its circulating draft chapter on training physicians for its March 31 report to the Congress, the Physician Payment Review Commission (PPRC) concludes that weighting DGME payments to hospitals is undesirable. The commission believes there are many existing slots for generalist training (which are unfilled), and weighting would have little influence on the decision making of hospital management and residency program directors. Finally, the PPRC concluded that weighting may not sufficiently penalize institutions oriented toward subspecialty training. In that regard, AAMC data for federal fiscal year 1991 indicate that Medicare patients constitute only 30 percent of patient days for academic medical center hospitals.

The administration's proposal would, however, eliminate the variation in the current per resident payment amount across teaching hospitals and reduce support for physicians in training. There are legitimate reasons why there have been variations in institutional costs among residency training programs, including the way the law has been interpreted by the Medicare fiscal intermediaries and providers, and differences in historical accounting practices.

The Congress should examine carefully the effect of this proposal on hospitals with small training programs. AAMC analysis of the HCFA data for the 56 teaching hospitals with per resident amounts in excess of \$90,000 reveals that these hospitals tend to have small training programs. The average training program in these 56 hospitals had 23 FTE resident trainees with a range from 2 to 269 residents. On average academic medical centers have 253 residents in training.

It is important to understand the internal institutional dynamics that will result from the implementation of preferential weighting proposals. Those disciplines with an increased weighting factor will argue that they deserve "more" of the direct GME funds for their residency programs. At the same time, other disciplines, as a result of reductions in fee revenue attributable to the implementation of the Medicare resource-based relative value scale, will increase pressure for more faculty salary support.

While supporters of preferential weighting proposals indicate that a higher payment differential will be enacted only for primary care disciplines, it is likely many clinical specialties will argue they also deserve a "special weighting factor." The AAMC notes that emergency medicine was added as a primary care category to the House Ways and Means Committee proposal two years ago, and physical medicine and child psychiatry immediately made a case for inclusion because these specialties are in short supply.

It is important to recognize that hospitals have not fully experienced the impact of the change in Medicare DGME payments legislated by COBRA. This legislation represented a major change in medicare payment policy from an open ended system to a prospective, capitated

amount. Implementing regulations were not issued until September 1989, and audits are not complete. Some hospitals have still yet to be paid under this "new" system.

Medical students' selection of residency training programs is not affected by Medicare payments to hospitals. On the contrary, personal incentives such as loan forgiveness, tax benefits, and other inducements are more likely to result in greater numbers of U.S. medical school graduates entering the generalist disciplines. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs.

Pressure from both federal and private payers to constrain the growth in health care expenditures, and changes in medical care delivery have produced significant tensions for residency and fellowship training programs. At the same time, the Association recognizes the frustration of government policymakers in assuring the public has access to generalist physician services. The AAMC supports strategies to develop additional generalist physician manpower, but this proposal to weight Medicare DGME payments based on specialty and length of training will only contribute to the instability of GME funding. Strong residency programs require continuity of effort and stable support. If future generations of Americans are to have appropriate access to well-trained physicians, we must maintain and strengthen our medical education system, including its residency training component.

Hospital Outpatient Department Payments

By enacting the Medicare PPS in 1983 as a way to pay hospitals for the cost of inpatient services, the federal government intended to slow the growth in health care expenditures and to give hospitals a financial incentive to provide services efficiently. One of the ways in which hospitals responded to these incentives was to shift the provision of some traditionally inpatient services to the outpatient setting. As a result, utilization of outpatient services has increased. In recent years, Congress has identified the need to control growth in Medicare outpatient expenditures and has modified the traditional cost-based reimbursement of hospital outpatient services in anticipation of a fully prospective payment system for all outpatient services. Some prospective pricing methods of payment have already been mandated for clinical laboratory services, many surgical services, and a number of outpatient diagnostic services. These different methods of payment constitute an interim step in the reform of the Medicare outpatient payment system.

While the details of a completely prospective payment system for outpatient services are still under consideration, the administration has proposed:

...reductions in hospital outpatient payments that extend the provision in OBRA 1990 of reasonable costs minus 5.8 percent, impose a further reduction of 4.2 percent on those services, and extend the 10 percent reduction in payments for outpatient capital costs.

The administration has offered no rationale or empirical evidence for these proposed reductions other than the need to control growth in expenditures for Medicare hospital outpatient services. The budget document estimates these proposals would save \$1.2 billion over four years.

The burden of this arbitrary proposed policy would fall disproportionately on teaching hospitals, potentially affecting access to services and quality of care available to Medicare beneficiaries and other individuals. Major teaching hospitals are larger and have more outpatient and emergency visits than community hospitals. In 1991, nonfederal members of the AAMC's Council of Teaching Hospitals (COTH) provided 56 million non-emergency outpatient visits. Although accounting for nearly 6 percent of the nation's hospitals, COTH members had 25 percent of all non-emergency outpatient visits. Many teaching hospitals, located primarily in urban areas, have established large clinics and primary care services to meet neighborhood health care needs and to provide a well-rounded educational experience for medical students and residents.

Recent changes in third party reimbursement, the growth of managed care, increased competition, controlled health care spending by state and local governments has caused teaching hospitals to experience financial stress with these financial implications ultimately impacting patient care and educational programs. The AAMC urges the Congress to consider carefully the overall impact of any reductions in these payments on the health care delivery system.

Mr. Chairman, thank you for the opportunity to testify and I am pleased to answer any of the subcommittee's questions.

Mr. LEVIN. Thank you very much.

I think we all appreciate the spirit which you bring to these issues. We are going to be voting on a budget resolution either today or tomorrow.

Let me try to be clear from the three of you about the mandated amount of cut for this fiscal year. Let's start with the Hospital Association.

Mr. Pollack, summarize again your position. You basically agree, though you want to provide suggestions on some specifics. Is that a fair description of your approach?

Mr. POLLACK. We obviously have problems with any further reductions. We know that you are about to be given a budget resolution, I guess by the end of today, directing you to meet a target, and we want to be realistic about that. While we don't like having to go through that process any more than perhaps you might, we recognize you are going to have to meet that mark. And we will have to help you reach the mark in a fair and balanced way as we move through that process.

Mr. LEVIN. And you think you will be coming up with some ideas as to how we do it that might differ from the part A suggestions that we have before us?

Mr. POLLACK. The chairman in his discussion earlier with Mr. Altman was suggesting one way in which you could go. That way has an elegance to it which is fairly interesting. I am not so sure that that is the way we would ultimately want to go, which is you can take it all out of the update.

There are others ways in which you can balance the package in a way to meet the mark. We will work with you to do that. I don't have the list today that would give you the exact balance that we think is necessary to reach the number, but we would want to work with you to take care that it is done in a balanced way so that we cushion the blows, if you will, with regard to those particular areas where there could be the most hurt.

Mr. LEVIN. I don't mean to put you on the spot unduly because I think the spirit that you express is the most vital. Do you share some of the concerns about balance that are expressed by your colleagues on this panel?

Mr. POLLACK. Absolutely.

Mr. LEVIN. You do.

Dr. Foreman, the State regulates hospital charges?

Dr. FOREMAN. Yes, sir.

Mr. LEVIN. Tell me, how has it worked?

Dr. FOREMAN. Was that objectively or subjectively? [Laughter.]

Do you mean by what means do they do it, or how effective has the regulation been?

Mr. LEVIN. I mean if you were advising the Governor, would you suggest that he repeal it, or ask its repeal?

Dr. FOREMAN. The New York system has worked in containing the acceleration of costs of the hospital community in New York. Charges for all payers except Medicare are under the control of the State department of health.

Unfortunately, in the minds of many of us, it has worked so effectively that it has compromised the fiscal integrity of many of the institutions in the State who have been unable to deal with rising

costs which race ahead of rising prices—the issue you discussed earlier. The State can control our costs, but it cannot control our prices.

This year, for instance, our rates were permitted to rise on an average of 2.5 to 3 percent, and our labor costs alone went up nearly 7 percent. So our input costs, like pharmaceuticals, medical and surgical supplies, labor, the cost of power, and all of the other things continue to rise out of proportion to the rate-controlled permissible prices in New York.

So, on the one hand, I think the good news is that a system of regulation can, in fact, bring down the acceleration of prices; but unless it is somehow or another tied to the acceleration of costs, one ends up ultimately squeezing the providers beyond the point where they can no longer accommodate by efficiencies.

Mr. LEVIN. Thank you.

Mr. Thomas.

Mr. THOMAS. I want to apologize to the panel for not being here for most of the testimony, but I had read it. And when you agree with it, it is harder to come up with questions.

My concern, as obviously indicated by some of your testimony, is that we are in the process right now of meeting current budgetary needs by the old process of ratcheting down Medicare. That has been a hoary practice that we have followed simply because that is “where the bucks are.”

We are going to be given a proposal, supposedly in May, that we are going to be looking at over some unknown period of time as we try to make adjustments to it. My fear is that as we enter into next year's budgetary cycle, we are going to have the same shortfall problems. And I appreciate anything that you can do with us, and I don't have a specific question. But we are going to be here—my greatest fear is we are going to be here in somewhat the same situation looking at—not even a freeze, but a ratchet down, at the same time we are supposed to be restructuring the rest of it. And my problem is that we are on a divergent course. We have been on a divergent course, and we are going to continue on this divergent course while we say we are solving the entire problem.

I guess the one question I would ask you was the one that came up with the chairman in the discussion with Dr. Altman; that is, the freeze, which winds up with about the same dollar amounts, or the proposed cuts with adjustments. You don't get the third choice, which is the one that I would support, but it is not available. If you had the option between the two, which one do you prefer?

I will ask anyone to respond.

Mr. POLLACK. Actually, to be honest with you, at this point I don't know what the answer is to that. We would have to think it through a little bit more carefully.

My instincts say I would rather come up with a balanced package, rather than going with a complete freeze, because I think that, if you go with the complete freeze while there is no redistribution and it is very clear cut, you don't have the opportunity to address some of the inequities that are in the system. So I guess it all depends upon how you define fairness in that case, but I can't give you a point-blank answer. My instincts tell me that I would rather try to come up with a balancing act.

Mr. GAGE. I think from the point of view of urban public hospitals, that the broader the pain is spread, the more quickly we are going to get to a position where we can translate these short-term cuts into reforms.

I think that simply carrying on as we have in the past with year after year of cuts and reconciliation bills is not the answer, and we wouldn't be as sanguine about supporting this level of cuts if we didn't think it could be translated into funding and support for reforms later in the year.

Dr. FOREMAN. I think that it is safe to say that representing both teaching hospitals who are targeted for a very substantial piece of these cuts and coming from the New York environment that you would not be surprised to hear me say that the cuts ought to be levied more broadly and more fairly than they are being proposed.

Mr. LEVIN. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. POLLACK, I am sure you are aware that in Maryland the performance has been rather remarkable for hospitals during this past year under our all-payer rate system; that our costs grew less than one-half the national average, 3.7 percent versus 8 percent, even though the cost of uninsured treatment rose by 28 percent. At the same time hospital margins in Maryland showed a dramatic improvement, increasing 85 percent.

With those types of results, I wonder whether your phone has been ringing off the hook from hospitals around the Nation trying to figure out how they can operate in such a favorable environment.

Mr. POLLACK. Well, certainly, the folks in Maryland have a lot to be proud of with regard to the system that they developed, but translating that to the national level creates an awful lot of problems, and there are a lot of differences between what goes on in Maryland and how it could work at the national level.

Of course, in Maryland you have an independent commission divorced from the political process, divorced from the imperatives of the deficit reduction process that makes decisions based upon health policy. Secondly and most—

Mr. CARDIN. If I could stop you on that point, Maryland works within the overall budget restrictions. The commission cannot work in vacuum of the realities of the dollars that are available. I am sure the hospitals in Maryland would like to get higher reimbursements.

Mr. POLLACK. The other point that is also very significant, though, as I understand the Maryland system is it is really very much a hospital-specific type of system, and I don't know that that kind of situation is applicable.

You actually have a review process where individual hospitals come in, and you have rates set for those specific institutions. While that may be applicable in that setting, I think it has real problems in terms of going at it on a national basis.

Mr. CARDIN. Is that because of the political environments in the other 49 States are not as favorable as that in Maryland where we can do objective rate setting?

Mr. BENTLEY. Mr. Cardin, if I could comment, I would like to try to put Maryland in a little perspective if I can and recognizing you

and I both live in that State and we have watched it for a long time.

I think there are some things that were unique about the Maryland situation. It genuinely was a hospital-Government cooperation that put the system in place. There is a relatively small number of hospitals compared to, say, the 6,000 hospitals or, in some States, 400 or 500 hospitals that have to be regulated if you follow that approach.

It is a relatively small area where the members of the commission and the staff are familiar with the geographic area and their features, and we are looking this year at the results of 20 years on the one hand and the general assembly meeting yesterday and today to talk about how inadequate what has been saved in the hospitals adds up to when they look at the whole health system. So they are now looking at—

Mr. CARDIN. Mr. Bentley, let me take back my time because I want to ask Dr. Foreman a question before my time expires.

I appreciate the differences between Maryland and the rest of the Nation, but the facts speak for themselves that Maryland has been extremely successful in keeping costs down through an all-payer rate system. As the hospital community looks for ways of more fairly allocating the burden, I would think that they would want to work in a system where not only are we saving money, but the hospitals are happy with our current system.

Dr. Foreman, first of all, we miss you in Maryland. It is nice to see you here.

Dr. FOREMAN. It is nice to be here.

Mr. CARDIN. We always appreciate your comments.

I want to ask you one question though. Your organization is asking, basically, for voluntary action in regard to the fact that we are not training enough physicians in primary health care as compared to those that go into residencies that are more costly.

The results haven't been very satisfying, and I think only two of the teaching facilities have produced a majority of medical students who are going into primary health care. That is not a very proud record if we really need to get the majority of our medical students going into primary health care.

What specific recommendations would you have in order to try to get more physicians trained in primary health care?

Dr. FOREMAN. The Association of American Medical Colleges has just completed its generalist physician task force study, and I am holding here a draft of the final report, which has not yet received full endorsement of the association, but I have little doubt that it will. And it has pages of recommendations, and those recommendations are targeted at the association itself, at medical colleges, at hospitals, and at Government to improve the desirability and attractiveness of primary care practice and to remove some of the barriers that now stand in the way. I would be happy to share those recommendations with you. They are really quite comprehensive.

However, I would like to call to your attention to a very interesting fact. Physicians do respond—young people do respond to the marketplace. For 10 years, applications to American medical col-

leges declined steeply, and reams of paper were cranked out to analyze that decline.

When the stock market crashed in 1987 and opportunities for bright young people in investment banking and the legal professions and elsewhere declined, applications to medical colleges began to rise, and they are now at an all-time high again.

What this suggests is that young people are sensitive to the world out there. Our world has not valued primary care physicians very much. I believe that as we move into more and more managed care and we do the things that our association is proposing, we will make those professions more attractive, and young people will seek them.

Mr. CARDIN. I appreciate the answer. It may well be that we haven't valued primary care enough or we may have valued specialized care too much or a combination of the two.

Dr. FOREMAN. Correct.

Mr. CARDIN. Thank you.

Mr. LEVIN. Mrs. Johnson.

Mrs. JOHNSON. Thank you.

Thank you, Dr. Foreman. That was a very important answer that you just gave.

When I talk to primary care physicians out there, there is no way that opening up more residency slots is going to attract more residents to primary care, and some of my medical directors are really worried about our trying to incentivize primary care residency slots when they can't fill the number that they have. I believe it is true that we are not filling all of the primary care residency slots at this time, and I would like to just confirm that.

But I also want to thank you for your Robert Wood Johnson Fellow, Dr. Irwin Merkatz, who was really such a help to us. Thank you very much.

But is that true that we are not currently filling all of the primary care residencies?

Dr. FOREMAN. That is correct. They are running now about a 20-percent vacancy rate.

Mrs. JOHNSON. I would like to have a copy of that report.

[The following letter was subsequently received:]



ASSOCIATION OF
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April 5, 1993

Charles N. Kahn
Minority Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1106 Longworth House Office Building
Washington, D.C. 20515

Dear Chip:

During the House Ways and Means Subcommittee on Health hearing on budget issues relating to payment under Part A of the Medicare program and payment for hospital outpatient and end-stage renal disease services, Mrs. Johnson asked for information relating to the residency matching rate for primary care residency positions. This letter provides the requested information.

Although the AAMC strongly supports more individuals entering generalist practice, the Association does not believe this proposal would achieve its intended objective of encouraging the training of more generalist physicians. The Association opposes proposals that intend to stimulate the production of generalist physicians by weighting DGME payments by specialty and length of training. There is no evidence that medical students' selection of residency training programs is related to Medicare payments to hospitals and there is no evidence that teaching hospitals will change the distribution of residency positions based on this incentive.

In its March 1993 Report to Congress, the Physician Payment Review Commission (PPRC) concludes that weighting DGME payments to hospitals is undesirable. The commission believes there are many existing slots for generalist training (which are unfilled), and weighting would have little influence on the decision making of hospital management and residency program directors. Finally, the PPRC concluded that weighting may not sufficiently penalize institutions oriented toward subspecialty training. In that regard:

- AAMC data for federal fiscal year 1991 indicate that Medicare patients constitute only 30 percent of patient days for academic medical center hospitals.
- Data from the 1993 National Residency Matching Program shows that of the first-year residency positions offered in "primary care" internal medicine, 61.5 percent were "filled" by graduates of U.S. medical schools. If foreign graduates are included, then the number of filled positions increases to 84.6 percent.
- 55.3 percent of the "primary care" pediatric residency positions offered were filled by U.S. graduates. If foreign graduates are included, then the number of filled positions increases to 76.3 percent.
- 63.2 percent of the family practice residency positions offered were filled by U.S. graduates. If foreign graduates are included, then the number of filled positions increases to 77.3 percent.

Please do not hesitate to contact me at (202)828-0525 should you have any questions about these corrections and answers.

Sincerely yours,

Mary Elizabeth Bresch White
Legislative Analyst
Office of Governmental Relations

cc: Richard M. Knapp, Ph.D.

Mrs. JOHNSON. I think one of the things we have to take very seriously is Government's role in driving primary care people out, including the very complex RBRVS requirements to delineate five different levels of office visit. So there are systemic changes that have to be made or nothing we do is going to drive people into primary care, in my estimation.

Dr. FOREMAN. It seems to me that the payment system is designed to torture primary care physicians.

Mrs. JOHNSON. Specifically, as opposed to others in the system?

Dr. FOREMAN. Well, I think that the primary care physicians see a lot of patients for short visits, all of whom are covered from different payment sources, and the paperwork creates a blizzard in the primary care offices. It is just unmanageable.

If you operate on 10 patients a month and see 20 more, you are issuing 30 bills. If you are seeing 100 patients a week in your office, you are issuing 400 bills per month, and it is very difficult.

Mrs. JOHNSON. I hope we will make some progress on that.

I want to ask the panel, and this is triggered in part by a rather narrow statement in your testimony, Dr. Foreman, but you say, on average, PPS margins, calculated without the IME or DSH payment adjustments that is only DRG, outlier, and end-stage renal disease use payments are minus 52 percent.

Dr. FOREMAN. That is correct.

Mrs. JOHNSON. Now, I don't think that we are commonly aware that the DRG payments are that much below for your kind of institution and what your costs are. You do then go on to say that the IME adjustment brings that minus 52 up to minus 9.4 and that the DHS payments bring it up to a plus of 3.8.

Dr. FOREMAN. Correct.

Mrs. JOHNSON. But looking at that one statement and recognizing the limits on our time, of all of the various cuts recommended and some of them in update figures, other hospital payment updates, but then the IME and the GME, which is most lethal? Where do we need to direct our attention, so we don't have such a disparate impact? Because while Mr. Gage thinks that this is going to be temporary and in a few months we will follow it with reforms that will contain more money, frankly, there isn't anyone out there who thinks that.

I just met with Mr. Magaziner this morning, and that is not a track that I see their 500 people able to perform on. So I think we have to be very serious about the fact that what we do this round in the budget is going to clearly affect every institution in the system for at least a year, and maybe 2 years. So I need your best shot at it, and you can follow up with details later, but where do we direct our attention?

Dr. FOREMAN. If I might, I would like to switch hats for a moment because the Association of American Medical Colleges does not have a position on where cuts should be taken. It has a position on where they should not be taken.

I am, however, a chairman officer of the Greater New York Hospital Association, and I know Mr. Raske is in the room and will permit me to speak on their behalf. He follows me.

I think we believe quite strongly that leveling those cuts across the system through the update factor would be the fairest and most

appropriate way to deal with any reductions that might have to be taken.

Mrs. JOHNSON. My time has run out, but if any of you want to get back to me on that subject, you are welcome to.

Mr. LEVIN. All right. Thank you.

By the way, on behalf of the minority, I would like to ask unanimous consent to allow Mr. Grandy to submit questions for the record of Mr. Toby and Dr. Altman.

Any objections?

[No response.]

Mr. LEVIN. It is so ordered.

Thank you very much. I think that we would probably, if there was more time, like to keep you, but we will have much more opportunity to discuss it.

We are going to have some votes, I think, in about 20 minutes, so maybe we had better move on.

[Questions for the record from Representative Andrews for Mr. Pollack and Dr. Foreman and their responses follow:]

Rick Pollack answer to Rep. Mike Andrews question for the record during Ways and Means Committee Health Subcommittee hearing March 18.

What is the difference between an AHP and a community care network?

Like accountable health plans, community care networks should be the delivery system for managed competition, but we see community care networks as having broader responsibilities.

Our idea for community care networks goes beyond that of accountable health plans, as we have seen them defined so far, in that network owners should be the organizers and predominant providers of care.

Networks also must be accessible and accountable to the communities they serve and be governed at the local level. One prime responsibility we would charge a community care network with is improvement of community health status.

There are many similarities between the accountable health plan requirements of your bill last year and what we would like to see in community care networks.

For instance, a few common responsibilities include: providing for all of the services covered for their enrolled population; measuring and reporting on satisfaction of network enrollees, providers, and practitioners; enrolling all applicants regardless of health status or need for health services, and reporting on financial solvency.



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April 5, 1993

Dave Kendall
Legislative Assistant
Office of the Honorable Andrews
U.S. House of Representatives
303 Cannon House Office Building
Washington, D.C. 20515

Dear Dave:

Enclosed please find the Association of American Medical Colleges' response to Representatives Andrews' question which is as follows:

There has been a lot of talk about the need for more primary care physicians. Can you give us three specific proposals for accomplishing this goal?

Pressure from both federal and private payers to constrain the growth in health care expenditures, and changes in medical care delivery have produced significant tensions for residency and fellowship training programs. The Association recognizes the present system has not produced the number of generalist physicians that society believes it will need in a reformed health care system. Concurrently, the AAMC recognizes the frustration of government policymakers in assuring the public has access to generalist physician services. A recent Association policy statement calls for:

an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

However, the AAMC is not convinced that weighting Medicare hospital payments for graduate medical education by specialty effect the decisions senior medical students make with respect to specialty choice nor is there evidence that teaching hospitals will change the distribution of residency positions based on this incentive.

The AAMC supports strategies to:

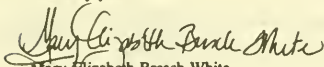
- develop additional generalist physician manpower and agrees that some changes in direct graduate medical education (DGME) funding will almost certainly be required to encourage residency training in non-hospital sites such as ambulatory, community-based non-hospital settings. As hospitals encourage shorter stays by more acutely ill patients, training in ambulatory and long-term care settings is needed to supplement the educational experience provided in hospitals to assure that residents receive comprehensive clinical training.

Dave Kendall
April 5, 1993
Page -2-

- reduce the marked disparity in income expectations resulting from our current system of physician payment. The Medicare program and other third-party payers should accelerate the transition to a resource-based fee schedule and should adopt other reforms in physician payment designed to compensate generalist physicians more equitably.
- reduce the complex and high volume of paperwork that primary care physicians are required to complete because of the great numbers of patients they treat during short office visits.
- allow the growth of managed care in the health care system to increase the reliance on and importance of generalist physicians, which will in turn elevate the attractiveness of being a primary care doctor. Once the market demands more generalists and rewards them appropriately, then more medical students will choose those specialties.

Please do not hesitate to contact me at (202)828-0525 should you have any questions about this statement.

Sincerely yours,



Mary Elizabeth Bresch White
Legislative Analyst
Office of Governmental Relations

cc: Richard M. Knapp, Ph.D.

Mr. LEVIN. Because of those votes, if the next two panels don't mind, I think we had better combine the two panels and hear the testimony from all five of you, and then we will ask questions because again, otherwise, we may have 25 or 30 minutes of votes as soon as the debate on the rule is over.

So it would be Mr. Raske from the Greater New York Hospital Association; Mr. Dauner; Bruce Yarwood; Maureen Michael, accompanied by Gwen Gampel; and also Dr. Lundin.

If you don't mind, I think there is a better chance that you will be heard this way. We appreciate your indulgence, but today was not a totally planned day. That is the understatement of the week.

We will hear all five. Why don't we take them in order. Let's see. We have your testimony in front of us. In each case, we had it beforehand, which was very helpful. Thank you.

You are not in any particular order. We will start with you, Ken, and then Duane Dauner, and then we will go on to the other three. Thank you very much.

Please proceed.

STATEMENT OF KENNETH E. RASKE, PRESIDENT, GREATER NEW YORK HOSPITAL ASSOCIATION

Mr. RASKE. Thank you, Mr. Chairman. It is a pleasure and an honor for me to be with you today to discuss the concerns that we have about the economic plan and forging a budget for fiscal year 1994 and the implications that has on the health care system in the New York City area.

I am here today to discuss a number of issues. Our testimony outlines a baker's dozen of highly technical concerns that we have, but let me, instead, spend the few minutes that I have with you this afternoon to talk about the foundation and philosophy that we have going into this budget discussion.

To begin with, many people look to the New York health care system as being some of the best aspects of health care delivery in the country. On page 2 of our testimony, we have an outline of some very interesting statistics. Specifically, for example, the occupancy rates in New York City hospitals are among the highest in the country. The number of full-time equivalent personnel per daily census is among the lowest.

When we talk about dealing with the epidemics facing society, the societal ills, the societal malaise that we have dealing of the drug problem, dealing with the AIDS problem, and dealing with the TB problem, yes, the New York City health care system is stepping forward and doing its best.

We have a chart that shows you the number of AIDS patients that we are treating right now, almost 2,500 patients, and the number of TB patients, almost 1,000. This is, on a day-in and day-out basis, the challenge faced by the New York City health care system.

But, like any system, it has its problems. You pointed out earlier in the remarks, of course, the fact that we are in a very stringent rate-setting State. That means there is an inability to shift costs to the private sector. That is limited by statute and regulation.

So part of the problem that we find are the cost pressures on New York City hospitals ends up on the bottom line. That is why

on page 3 of our testimony, you will note the negative operating margins in toto for the voluntary hospitals, and then when you combine them with the public institutions, the NYC Health & Hospital Corp., specifically, it bleeds in red ink.

So, with that as a backdrop, ladies and gentlemen, I would like to comment very briefly on the economic plan and the fiscal year 1994 budget proposals.

Number one, in terms of concern for us is the cut that is being proposed in direct medical education. We are ground zero on the hit on direct medical education. Out of the \$350 million that is being scored, from a Federal standpoint, we estimate about half will be in New York City hospitals—about half.

That means that these institutions who have negative margins to begin with, who have the pressures of dealing with all the patients that we are dealing with today will have to find \$175 million, and it won't be from private-pay patients. It will come right out of patient care.

So I submit that that kind of cut is a significant cut, a disastrous cut, and we would request the committee and your colleagues to push that cut back.

We understand full well, of course, that you do have to deal with budget marks yourselves and that some goals must be met, and, of course, as mentioned earlier, we would think that the broadest base pain, if there is going to be pain at all, is the best way to go.

With respect to issues which come back from the last administration, there are a whole host of problems that we have with respect to capital formation which, of course, is the essence of keeping an industry alive in the future.

The capital regulation, which integrated the prospective payment system into some sort of unified rate, is a complex regulation which has enormous technical aspects to it. In fact, I think a whole consulting industry has started up just around that regulation itself.

The problems are significant when you put them in a severe regulatory context like New York. Timing of certificates of need, when buildings come up and online and when, in fact, transition periods occur. Well, we have a number of technical requests that need to be satisfied in relationship to that regulation in order to make it work in New York. Today, it does not work.

Finally, I want to compliment the committee specifically for dealing with the tough issues of the disproportionate share adjustments. It is this committee who has pushed that adjustment for a number of years. I believe that in the absence of universal health insurance, it is the only thing that is saving the inner-city institutions from the kinds of pain and anguish that they would be receiving otherwise. So my compliments on good work and continued vigilance on the issue of the disproportionate share adjustment.

My final summation remark, Mr. Chairman, is simply this. Why do health reform twice? In point of fact, some of the programmatic responses that are in the budget proposal that the administration is submitting do deal with health reform in a very significant way; specifically, of course, the direct medical education cut.

Outside of a budgetary context, it means simply this, that you are reshaping the health care system through the medical education component. We know full well that will be part of the rec-

ommendations coming out of the task force and, eventually, will be brought before this body.

I submit that the anguish and anxiety that health care reform creates around the Nation should be dealt with once and these cuts should be dealt with at that time.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

GNYHA

GREATER NEW YORK HOSPITAL ASSOCIATION

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Kenneth E. Raske, President

**TESTIMONY
OF THE
GREATER NEW YORK HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
ON
BUDGET ISSUES RELATING TO PAYMENT
UNDER PART A OF THE MEDICARE PROGRAM**

Thursday, March 18, 1993

Good morning, Chairman Stark, members of the Subcommittee, ladies and gentlemen. My name is Kenneth E. Raske and I am President of Greater New York Hospital Association (GNYHA), which represents 152 voluntary, non-profit and public hospitals and nursing homes in the metropolitan New York area. GNYHA greatly appreciates this opportunity to present its views on budget issues relating to payment under Part A of the Medicare program.

Given that the forces for health care reform have never been more powerful than they are today, GNYHA must necessarily view Medicare Part A budget issues as part of a continuum of changes leading to health reform. Furthermore, how New York City area hospitals fare under Medicare Part A in the Federal fiscal year 1994 Budget will materially influence their fiscal buoyancy in the context of health care reform.

My statement today will focus on three particular components of the Part A Medicare program, which are profoundly important to hospitals in the New York City area and, presumably, to urban and inner-city hospitals nationwide. These include Medicare payments for graduate medical education and capital-related costs, as well as support in the disproportionate share adjustment for hospitals that provide a substantial amount of uncompensated care.

In the context of these priorities, I will present my views with respect to some of the Medicare budget proposals that are currently under your consideration. Also in the context of these priorities, I will discuss a number of outstanding Medicare Part A issues that were carried over from the previous Administration and that have been plaguing GNYHA members for the past several years.

Having reviewed the current Medicare budget proposals juxtaposed with the other Medicare issues carried over from the previous Administration, we are overwhelmed by the disproportionate harm that certain provisions would cause to New York providers. It has been estimated that various proposals under consideration could cost New York City hospitals at least \$400 million in Federal fiscal year 1994 alone, with such losses totaling more than \$3.3 billion over a five year period.

We believe that some of the proposals would be so damaging to New York City area hospitals that they should not be implemented outside of the context of a health reform strategy in which cuts in payments would presumably be offset by gains in health insurance coverage. Yet, it would be counterproductive to take up the health reform analysis twice, once in the context of the budget discussion and again in the context of the Administration's formal health reform proposal, which could maintain, modify or even reverse positions taken at this time.

We, therefore, strongly urge you to postpone consideration of the more "programmatic" Medicare Part A proposals and to achieve any requisite Medicare budget savings at this time in a manner that fairly spreads the pain among all hospitals, rather than concentrating the deleterious effects among urban institutions.

Outlined below is an overview of the unique environment in which New York hospitals operate and the needs derived from that difficult environment. The balance of my statement is devoted to the three Medicare Part A priorities that I previously identified.

NEW YORK'S UNIQUE ENVIRONMENT

Many aspects of the hospital system in New York are a manifestation of what many believe to be the "best" or most sought after in the health care delivery system: namely, a system in which the rise in health care expenditures and costs to consumers have been controlled by stringent rate regulation, while the health care community continues to fulfill its mission of delivering quality services to all who are in need.

Indeed, by many measures of efficiency in the production of health care services, New York's hospitals score well. For example, New York State hospitals' median number of full-time equivalent personnel per occupied bed is the lowest in the nation. These same hospitals are running near capacity, with occupancy rates in New York City nearing 90% routinely.

FTEs PER AVERAGE DAILY CENSUS (ADC)

1991 Comparative Data

California	5.2
Illinois	5.0
Connecticut	4.8
U.S.	4.7
Florida	4.5
Maryland	4.3
Pennsylvania	4.2
Massachusetts	3.9
New Jersey	3.8
New York State	3.7

Source: HCIA and Deloitte & Touche

OCCUPANCY

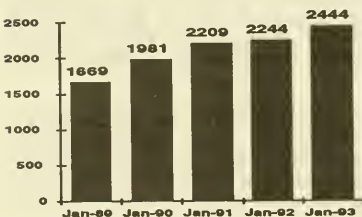
1991 Comparative Data

U.S.	66.1%
New York State	85.3%
New York City	87.7%
Chicago	73.2%
Los Angeles	64.3%
Philadelphia	77.1%
Houston	61.9%
Detroit	70.8%

Source: American Hospital Association, *Hospital Statistics*

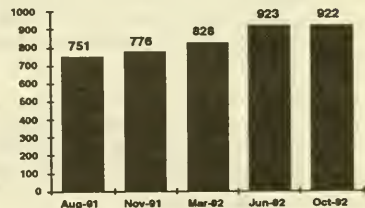
New York State's hospitals also earn high marks for their service to the elderly, poor and uninsured, providing approximately \$1.5 billion worth of uncompensated care each year, much of which is delivered to these most needy groups. The rush of public health epidemics has also found an able response from hospitals in New York City that care for some 2,444 patients with AIDS and 922 patients with tuberculosis on a daily basis.

NEW YORK CITY AVERAGE DAILY AIDS CENSUS



SOURCE: GREATER NEW YORK HOSPITAL ASSOCIATION

New York City Average Daily Census Hospitalized Tuberculosis Patients

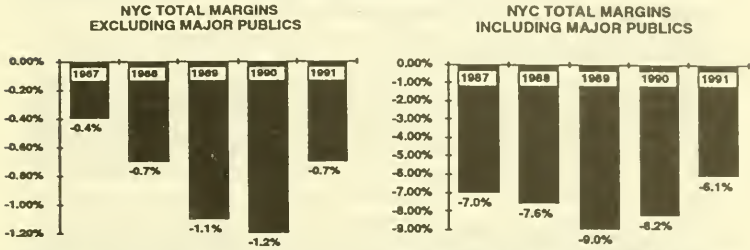


SOURCE: GREATER NEW YORK HOSPITAL ASSOCIATION

Also on a daily basis, New York's hospitals are expected to respond to personal or public tragedies. On February 26, 1993, for example, the hospital community and Emergency Medical Services, operated by the New York City Health and Hospitals Corporation, working as a team, helped immeasurably in caring for the injured in the aftermath of the explosion at the World

Trade Center. If, as they say, a tragedy brings out the best in New Yorkers, a tragedy also sets a spotlight on the heroics of the health care community—work that takes place almost unnoticed and unheralded every day. This tragedy underscored the value of New York's health care system in human terms, and the need to ensure its viability.

Unfortunately, the consequence of some of these efficiencies is a hospital system that is, quite simply, in a precarious financial condition. In 1991, voluntary hospitals in New York City experienced bottom-line losses of approximately \$16 million. When public hospitals are added, those losses total \$138 million. In fact, New York hospitals have sustained negative bottom-line margins for the past five years, as presented in the following tables.



Source: Institutional Cost Reports (ICRs), as compiled by the Center for Health Policy Studies.

Source: Institutional Cost Reports (ICRs), as compiled by the Center for Health Policy Studies.

The combination of the tremendous demand for care by extremely needy populations and persistent bottom-line losses has produced other indicators of the financial ill health of New York hospitals. According to William O. Cleverley, Ph.D., C.P.A., Professor at Ohio State University:

New York State hospitals have very little short term or long term liquidity. This simply means most New York State hospitals have cash reserves that are large enough to meet only current needs for payroll and supplies, with little if any funds available to meet long term needs for added working capital and replacement.

(Financial Review of New York State Hospitals for the Period 1989 to 1991)

It is with this background and experience that I present the needs of the New York health care community today and portray to you the importance of all payers, including Medicare, to our future.

GRADUATE MEDICAL EDUCATION

New York State, which trains more than 15% of the nation's resident physicians, is home to some of the world's premier institutions of medical education and biomedical research. The scope of its educational and research mission has helped it earn a national and international reputation as a center of medical excellence. In addition, in New York City, the size and scope of medical residency programs has played an important role in the delivery of health care services to the poor and medically underserved through the provision of supervised resident physician care in areas where there are few, if any, private physicians.

The importance of medical education programs to New York City's hospitals, the physician supply needs of the nation, and the service needs of the City's residents cannot be overstated. Yet, among the Medicare budget proposals before the Congress are reimbursement changes that would severely and inequitably curtail direct graduate medical education (GME) and indirect medical education (IME) funding. It has been estimated that each of these proposals could cost

GNYHA member teaching hospitals as much as \$200 million on an annual basis when fully implemented.

In addition, we are awaiting the resolution of several outstanding audit and administrative problems that were encountered by GNYHA member hospitals in the transition from a GME pass-through to a prospective per resident reimbursement methodology, but which were not settled by the previous Administration. The proposed GME and IME cuts combined with the outstanding audit issues threaten New York City's important teaching programs, the hospitals that sponsor them and, most importantly, the patients that they serve.

The following sections will more fully develop GNYHA's position with respect to the proposed GME and IME cuts, as well as the outstanding GME audit issues.

Direct Graduate Medical Education (GME)

Of all the Part A Medicare proposals, the most harmful to GNYHA member hospitals is the curtailment and reallocation of Medicare funding for GME, because it appears that this proposal would disproportionately impact urban and inner-city teaching hospitals. While the GME proposal is projected to save the Medicare program \$350 million in FFY 1994 and \$1.36 billion over four years, GNYHA believes that at least 50% of this cut could be unfairly sustained by New York City voluntary teaching hospitals alone.

Under current law, Medicare GME payments include at least five components: resident salaries, fringe benefits, and the personnel costs of supervising attending physicians, as well as administration and overhead costs. These components are currently reimbursed on the basis of a per resident amount, which is calculated according to 1984 trended, hospital-specific costs.

We believe that the proposal before you would no longer reimburse hospitals for all five GME cost components, because it would reimburse hospitals with a new per resident amount based solely on a national average resident salary. In addition, the proposal would differentiate GME payments to hospitals in favor of primary care residents. The interplay of these two aspects of the proposal would have the effect of lowering the national average per resident amount by about 18%. However, the brunt of this approach would disproportionately and, perhaps, inadvertently fall directly on the backs of urban and inner city teaching hospitals that provide significant amounts of indigent care, a result that would be devastating to New York City teaching facilities.

- Regional Differences in Funding Sources for GME Supervision Costs

First, the reduction in reimbursement for supervising physician costs through the GME per resident amount fails to recognize that certain urban hospitals are significantly more dependent upon Part A GME funding for their teaching activities than are many of their national counterparts, due to the demographics of their patient populations. While New York City is home to some of the nation's premier teaching and research institutions, it is also home to a population in which more than 20% of the residents are Medicaid eligible and, by some estimates, a similar percentage is uninsured. Further, almost 30% of the City's voluntary hospital inpatient discharges are represented by Medicaid, compared with a median of about 11% for voluntary hospitals nationwide.

In order to deliver care to indigent and uninsured individuals, many of whom have no personal physician, these hospitals depend heavily upon their residents. The practice and reality in the New York City area is that supervising physicians do not and cannot bill for the professional services rendered to such patients. As a result, hospitals compensate the physicians for supervising the residents who deliver much of this care. According to the Chairman of the New York State Council on Graduate Medical Education (COGME):

By drastically cutting out these [Medicare Part A GME supervision] payments, this proposal penalizes only those regions and hospitals which, because of their large indigent populations, have had to rely on a different model of care.

In areas of the country that do not have such large numbers of indigent patients, most teaching takes place as part of the process of the attending physician's delivery of care to his or her own private patients. In such instances, the physicians generate significant professional billings while teaching, and the hospitals, therefore, pay the physicians much less in the way of a salary for the teaching and supervision functions. The fact that New York has one of the nation's lowest levels of Medicare inpatient Part B billing for physician services was evidenced in a recent study by the Urban Institute in Washington, which was published in The New England Journal of Medicine.

- Hospitals' Limited Influence over Residents' Specialty Choice

Furthermore, the aspect of the proposal that would impose a payment weighting system on residents according to their specialty is one that I believe addresses a very complex problem in a simplified and unstudied way. Before addressing this concept in more detail, I would like to point out that New York State has had a moderate weighting system in effect for more than a year. Yet, even major proponents of this system have recommended that no further weighting be imposed until it is seen whether this practice has any demonstrable impact on ameliorating the shortage of primary care physicians or whether it is merely a technical reimbursement exercise that shifts money among providers.

The training of primary care physicians has a starting point in the medical schools and a finish line in the practice environment. Hospital residency programs, which come in the middle, have little or no control over the activities at either end. Studies by the Council of Teaching Hospitals (COTH), for example, have shown that medical students make their residency choices by the third year of medical school, i.e., well before they step foot into their chosen hospital residency track. In addition, relatively low physician fee reimbursement coupled with a high level of debt incurred in medical school make the choice and ultimate practice of primary care a financially daunting one.

These two factors may explain why New York's hospitals in 1992 were able to fill only 65% of available residency positions in Family Practice and only 67% of available slots in Pediatrics. Yet, difficulty filling existing primary care positions is not solely a New York phenomenon; it is a national problem.

Unless and until substantive and measured efforts are made to address the shortage of primary care physicians at the start and finish lines of physician specialty choice, hospitals' inability to fill existing primary care positions will not have been addressed in a meaningful way, and residency weighting programs will result in inappropriate and unfair financial penalties. Again, according to the Chairman of COGME:

These massive reductions to GME programs in New York State will, in fact, destroy the opportunity for rational primary care-oriented reform of GME programs.

Finally, even in conjunction with efforts at the medical school and practice environment levels, weighting should not be undertaken until there has been a thorough evaluation and determination that it will contribute to achieving the goals sought and until a more scientific way of setting the weights has been identified.

Indirect Medical Education (IME)

Another Medicare Part A proposal before you would phase in a reduction of IME payments to teaching hospitals beginning in FFY 1996. It is estimated that, again, New York City's hospitals would suffer dramatic losses as a result of these cuts.

The IME adjustment to the PPS rates represents an important, although imperfect method of compensating teaching hospitals for the additional patient care costs associated with conducting programs in graduate medical education. These extra patient care costs result from increased diagnostic testing, higher volumes of procedures, greater staffing ratios and the need for increased medical documentation and recordkeeping. The IME adjustment is an estimation of

these additional costs because it has been very difficult to precisely identify them. The fact that an IME adjustment is provided at all reflects the fact that there is no other component of the Medicare inpatient DRG reimbursement system that accounts for these significant and legitimate costs.

Because IME payments are based on an estimated measure, they are a potential target of rate reduction efforts. However, studies to date to improve the identification of "true" IME costs have been very limited and subject to criticism from a technical perspective. While the Prospective Payment Assessment Commission (ProPAC) has cited findings that the appropriate IME adjustment may be lower than the current adjustment, a January 1989 Government Accounting Office (GAO) report on Medicare IME payments noted that there are certain measures of hospital inputs and outputs that contribute to the explanation of differences in hospital costs, but which have not been included in the study of IME costs.

Some of these other measures include additional measures of severity of illness, regional variations in medical practice patterns, and other characteristics of a hospital's market area. The GAO report noted that to the extent that these factors can be measured accurately, their inclusion might affect the estimation of IME costs. IME is a significant component of the PPS rate structure to teaching hospitals. Until we can more precisely understand the indirect impact of teaching programs on operating costs, the Medicare program should not make any changes in the IME payment methodology.

Shortcomings of other aspects of PPS combined with recent payment limitations for GME and capital costs also support the continuation of IME payments at their present level. For example, teaching hospitals typically have higher case-mix indices than other hospitals. However, there is broad-based concern that the DRG weights do not accurately reflect the high case-mix levels at teaching hospitals. Furthermore, the recent changes in payment methodologies for GME and capital costs have placed additional limitations on payments to teaching hospitals and, hence, on their ability to cover reasonable operating costs and offer significant programs in graduate medical education. With other components of the inpatient rate system severely constrained, a very strong argument is made for the continuation of IME payments at the present level.

Unresolved GME Audit and Administrative Issues

GNHYA member hospitals have a host of unresolved issues that arise from the implementation of a change in the existing GME reimbursement methodology, enacted by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. This legislation converted payment for GME costs from a pass-through methodology to a prospectively determined, hospital-specific per resident amount, based upon 1984 cost data. Although the change was legislated in 1986, to be effective immediately, it was not until late 1989 that the U.S. Health Care Financing Administration (HCFA) promulgated final implementing regulations, and it was not until 1990 that the ensuing audits of 1984 costs began.

The bottom line problem for GNYHA member hospitals is that the audits have resulted in the inappropriate disallowance of large amounts of legitimate 1984 base year GME costs, which will be forever lost in the historically-based per resident amounts. The disallowances have been generated and compounded by: (1) HCFA's delay in implementation; (2) the unprecedented reaudit of previously audited data; and (3) confusion regarding the nature of GME and the 1984 documentation available.

In December, 1991, HCFA designed a resolution process, which GNYHA hoped would achieve the avoidance of inappropriate and possibly crippling GME underpayments. In mid-1992, in response to HCFA's request for information, GNYHA submitted a detailed report on the nature and value of the audit adjustments at issue and the relief requested. HCFA has yet to notify GNYHA of its determinations on these issues.

Specifically, GNYHA has requested:

- That HCFA rely upon the more precise, audited 1990 data as a proxy for 1984 data to

explain all legitimate GME activities performed in the 1984 base year, because the actual 1984 documentation instructions and forms supplied by the Medicare fiscal intermediary yielded inadequate information. HCFA had permitted this relief on a national level, but has since arbitrarily limited the use of these data;

- That HCFA permit the reclassification of costs from operating cost areas to GME, again based upon audited 1990 data, as specifically permitted by HCFA's own regulations that allow such reclassifications; and
- That HCFA develop a process involving representatives of HCFA, the fiscal intermediary and the affected hospitals to resolve various documentation and classification problems and inequities that have arisen during the audits.

Without this relief, New York City teaching hospitals stand to face arbitrary and devastating takebacks of GME payments, and have already experienced significant underpayments for GME during recent years. We hope that there will be a timely and equitable administrative resolution of the outstanding issues pertaining to the determination of GME payments.

CAPITAL FORMATION

Ensuring adequate capital formation is one of the most important issues to New York hospitals, as for hospitals elsewhere in the nation. It is also among the greatest concerns of New York hospitals due to their overall weak financial condition, poor liquidity and high debt loads. Adequate reimbursement for capital-related expenses, by all hospital payers, is, of course, a key factor in capital formation.

Among the Medicare Part A budget proposals before you is a continuation of the current practice of reconciling total Medicare capital payments to 90% of total Medicare capital costs. Our view is that this proposal should not be implemented because it would exacerbate the debilitating effect on New York hospitals of the current flaws in the capital PPS, which will become more evident as the capital PPS transitions to full implementation.

During the past eighteen months, GNYHA has made specific recommendations to HCFA that would correct the deficiencies in the capital PPS and, thus, provide a more equitable and appropriate level of Medicare capital reimbursement for certain New York hospitals. However, implementation of our recommendations has not moved forward.

- Changes Needed to the Capital PPS Obligated Capital Special Rule for Hospitals in CON States

The changes that GNYHA has recommended to the Medicare capital PPS in order to facilitate adequate capital formation for New York hospitals fall into two categories. The first set pertains to the unique problems that New York area hospitals face in negotiating their way through the arduous New York State Certificate of Need (CON) process and the New York City land use approval process. While the obligated capital provision special rule for hospitals in CON states was established expressly to accommodate these problems, the requirements of the special rule are currently too restrictive to afford adequate relief. In order for this provision to cover several, clearly obligated, New York major modernization projects for which millions of dollars have already been invested, the following changes must be made:

- Extend the deadline by up to nine months for both filing a CON preapplication and for not having received either approval or disapproval on the condition that the fiscal intermediary can verify either: (1) that the hospital submitted to the State Health Department a master plan or capital needs inventory containing a description of the project to follow by December 31, 1986; or (2) that the hospital expended in excess of \$1.5 million by September 30, 1990.
- Provide that if the initial phase of a major modernization project met the deadline for CON preapplication, then the fiscal intermediary may deem that a later phase of the project has also met the preapplication deadline if the fiscal intermediary can verify that the capital-related

costs in the later phase were related to and were an integral part of the hospital's original project plan when the first CON application was submitted.

- Extend the deadline for completion of obligated capital projects by up to 36 months beyond September 30, 1996, as required by the individual modernization program.

- **Extension of Transition Period Needed for Obligated Capital Projects**

Furthermore, the transition period for obligated capital payments must be extended at this time. Unless hospitals are able to assure the investment community that they will be able to meet their debt service and other capital-related obligations in the future, based upon adequate Medicare reimbursement, a cascading effect will occur in which hospitals will not be able to secure financing, they will consequently be unable to enter construction contracts, and their projects will, therefore, not be able to move forward. During hearings on the capital PPS, HCFA officials told the Congress that the agency would address the need for an extended transition period toward the end of the current 10-year transition period. For the foregoing reasons, it is vital to implement extensions now, such that the following change is recommended:

- Provide a 10-year transition period for each major phase of an obligated capital project.
- **Payment Floor Extension Needed for Disproportionate Share Hospitals with New Capital**

The second category of recommended changes addresses the problems of so-called "new capital" hospitals in the New York area whose major modernization projects had been planned to commence during the 1990s. The theoretical underpinning of the capital PPS is that hospitals will fund capital-related obligations in higher-than-average cost years through earnings retained during lower-than-average cost years. However, hospitals whose capital cycles require rebuilding in the 1990s will not have had sufficient time to accrue retained earnings to meet their financial obligations, assuming that their financial condition supported such accruals.

These projects cannot be postponed, however, due to the urgent nature of the renovations. Nor can they be funded through alternative financing sources, since such sources are generally not available to financially stressed hospitals serving a disproportionate number of elderly, poor and uninsured patients. While the 80% payment floor for high disproportionate share hospitals was established to ameliorate this problem, it is not guaranteed throughout the transition period and ceases altogether after the year 2001. Therefore, the following recommendation should be promulgated:

- Maintain the transition period cumulative payment floor for high disproportionate share hospitals at 80% of actual Medicare inpatient capital-related costs and extend the 80% cumulative payment floor for high disproportionate share hospitals for ten years beyond the transition period.

COVERAGE FOR UNCOMPENSATED CARE

Until some form of universal insurance coverage is fully implemented, facilities that treat a large number of uninsured and indigent patients must have some vehicle for covering the costs of their uncompensated care, which like for any other industry is a cost of doing business. Absent any other vehicle, it is essential that Medicare Part A continue to fully fund the disproportionate share (DSH) program, which provides crucial support to hospitals serving the medically indigent. Furthermore, as insurance coverage is expanded under health reform, it will be imperative not to curtail DSH funding prematurely, but to ensure its adequate support for essential, safety net providers that may need assistance in order to remain viable during the transition to universal coverage.

In addition, given the fragile financial condition of New York hospitals combined with the high level of uncompensated care that they render--which is often associated with individuals afflicted by the City's public health epidemics--it is crucial that we avoid arbitrary or precipitous

redistributions of Medicare Part A funding. Several redistributive proposals are under consideration or have already been implemented without a sufficient phase-in period to allow hospitals to adjust to the loss of funding. These proposals pertain to outlier funding and the Medicare area wage index.

Funding for Day Outliers

In FFY 1993, HCFA promulgated two changes in the day outlier payment formula, which were based upon recommendations by the RAND Corporation and which cost New York City hospitals about \$70 million. These changes were unfairly implemented without a phase-in period, despite the fact that GNYHA had apprised HCFA of the projected losses and had requested a phase in to the new formula, at least pending an independent validation of the RAND findings.

HCFA has reported that it is considering a third change to the day outlier payment formula, which would cause further losses to New York City providers. The agency is also reviewing a recommendation by ProPAC to totally eliminate day outlier payments. We urge that any further changes to day outlier funding be gradually phased in, given the burden such changes would place upon New York City Medicare providers.

Calculation of the Wage Index Based Upon an Expanded New York City MSA

Among the most devastating potential Medicare funding cuts to New York City area hospitals was one that was not even a deliberate Medicare proposal. It would be an unintentional result of the Office of Management and Budget's (OMB) proposed expansion of the New York City Metropolitan Statistical Area (MSA), which also has no programmatic basis. HCFA traditionally uses the MSAs as labor market proxies in calculating geographic wage adjustments to the Medicare payment rates. If OMB proceeds with combining nine formerly separate MSAs into a single, mega-MSA and HCFA uses this expanded definition to calculate the FFY 1994 area wage index, then the result will be the dilution of the New York City area wage index, which could cost New York City hospitals an estimated \$121 million in urgently needed Medicare revenue.

The expansion of the New York City MSA would be highly inappropriate in and of itself, because the consensus among all the affected regions is that, for statistical purposes, the areas should remain separate. Since publication of the expanded New York City MSA in December 1992, OMB has received sufficient protest to reopen the process. The final definition of the New York City MSA will be published in June.

Irrespective of the MSA's definition, however, HCFA's use of an expanded New York City labor market would be highly inappropriate at a time when the industry is studying smaller labor market proxies due to a consensus that the MSAs are poor proxies. In January, ProPAC proposed a methodology of calculating hospital labor markets that would be based upon each hospital's ten nearest neighbors.

Unfortunately, HCFA officials have told GNYHA that the agency intends to use the revised MSAs in calculating the FFY 1994 Medicare area wage adjustments due to insufficient time to propose an alternative for this year. GNYHA has recommended that pending conversion to an alternative methodology, HCFA should use the current, smaller definition of the New York City MSA, since HCFA has a responsibility to ensure an equitable payment policy for Medicare providers. We hope that HCFA will affirmatively respond to this request.

CONCLUSION

On behalf of our members, GNYHA thanks you for the opportunity to testify and to share the realities of delivering health care services in the urban environment of New York. As always, GNYHA and its members are available to this Subcommittee and to the Congress to provide additional information, as requested.

Mr. LEVIN. Mr. Dauner.

STATEMENT OF C. DUANE DAUNER, PRESIDENT, CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

Mr. DAUNER. Thank you, Mr. Chairman. I am Duane Dauner, president of the California Association of Hospitals and Health Systems, and I am pleased to be here on behalf of the 500 hospitals in our State.

We endorse the intent and the philosophy of the President's economic goals, but we do so in the context of health care reform. If taken in isolation, the fiscal year 1994 budget represents a continuation of ratcheting and hatcheting that Mr. Thomas referred to earlier, and we end up in a conflict with reforming the system over the long term.

As you know, these cuts come on top of OBRA 1990 reductions, and they obviously make us anxious because we don't know where we are going in the future.

Hospitals find themselves in a price vise; specifically in our State, Medi-Cal cutbacks due to a severe State budget shortfall, reductions in funding to local governments for health services, and a growing uninsured population must be balanced against the factors that affect hospital costs.

In addition to the things that have been said by previous speakers, certain States are disproportionate States. In New York, Florida, Texas, and California, undocumented immigrants, AIDS patients, and so forth have a profound impact on the way hospitals and the health care delivery function and, therefore, must be adequately financed.

Hospitals around the country have made strides as was reported earlier by the representatives of ProPAC. Specifically, we have been successful in the last 10 years in reducing per capita costs in our State to 7 percent below the national average. That has not come easily.

Competition has done some things good. It has also had its down sides. But the fact is that we are seeing a tremendous shift from inpatient services to alternative care.

Collaboration is something that is drastically needed, and the Chairman of the committee and many of you have been important advocates for reducing the antitrust barriers to collaboration and arrangements which improve access and quality while containing costs.

We believe that systemic and fundamental reforms are needed in the financing, payment, and delivery systems of health care. We hope that reforms can be achieved and that any short-term budget cuts do not work at cross-purposes with that long-term objective.

Reference has been made to a recent report that the task force on national health care reform is considering short-term price controls. Whether it is a freeze on provider prices, on insurance carrier rates, or extending the Medicare payment system to all payers, they have one underlying disadvantage. They lock in the status quo. They tend to strangle hospitals and other providers. It will hurt the essential and safety-net providers that are least able to cope with such caps and actually will work against meaningful long-term health care reform.

We stand ready to pursue and enact systemic and responsible health care reform. We hope that the budget reductions that this committee will have to face will not work at cross-purposes against our broader objective to serve society.

Thank you very much.

[The prepared statement follows:]

TESTIMONY

**C. Duane Dauner
President**

California Association of Hospitals and Health Systems

Good morning, Mr. Chairman and members of the subcommittee, I am C. Duane Dauner, President of the California Association of Hospitals and Health Systems (CAHHS). On behalf of CAHHS's 470 member hospitals, I am pleased to testify today on the President's Fiscal Year (FY) 1994 budget proposal, as well as on the continued long term viability of our national health care delivery system.

As a part of the President's economic stimulus package, the Administration has proposed to reduce estimated Medicare and Medicaid spending by \$62.6 billion over the next five years. The FY 1994 impact on hospitals will amount to a reduction of nearly \$2 billion in Medicare revenues while the five year impact will reach nearly \$23.7 billion. The Department of Health and Human Services (DHHS) has indicated that hospitals will carry the largest burden -- 38 percent of all Medicare cuts-- over the FY 1994-98 period. We are aware that these proposed cuts, in the words of Administration officials, are simply "nicks". Real cuts, we are told, are still to come.

While hospitals are willing to carry their fair share of the sacrifice necessary to assure appropriate access to health care for all Americans, we believe such sacrifice should occur in the context of health care reform. There is only so much each hospital can contribute to this cause and still maintain sufficient financial vitality and ability to serve its community. California hospitals are quite frankly, nervous when first the Administration proposes Medicare cuts totaling nearly \$24 billion over five years and then says that the worst is yet to come.

First, before examining the implications of the Administration's proposed FY 1994 spending plan, it is important to remember that these proposed reductions, if enacted, will fall on top of the nearly \$25 billion of Medicare spending reductions, \$8.1 billion of which is in the form of hospital cuts, enacted as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) that are already in scheduled for FY 1994 (\$11.37 billion) and FY 1995 (\$13.57 billion). And OBRA-90's Medicare cuts, totaling over \$43 billion for the five year period FY 1991 through FY 1995, were just another set of waves in a steady and unrelenting pattern of Medicare cuts that have been battering hospitals since the mid-1980s.

Second, these past and present Medicare cuts have had a telling impact on hospitals' Medicare profit margins. According to ProPAC, hospitals' PPS profit margins are projected to have fallen to a negative 8.3 percent for fiscal year 1992 - more than doubling 1991's negative PPS profit margin of 3.6 percent. Just as the national debt consumes our nation's financial resources thus denying their availability to revitalizing our nation's economy, so these mounting Medicare losses increasingly limit California hospitals' abilities better to respond to their communities' needs.

Further, we are particularly concerned about the impact of these Medicare losses on our most vulnerable California hospitals which provide access to health care services for our nation's poor, elderly and rural citizens. In fact, ProPAC cites concern that "the continued operation of these hospitals and the fulfillment of their unique role in the provision of health care might be impaired by a substantial immediate reduction of Federal support."

Next, while, as noted above, we are willing to carry our fair share of the "sacrifice," nonetheless California hospitals are concerned that the FY 1994 budget proposal appears to be a continuation of past administrations' arbitrary efforts to take as much as possible out of hospitals without considering the consequences.

- o For California, in FY 1994, moving the effective date of the annual update from October 1, 1993 to January 1, 1994 will result in a \$81 million cut, while the proposed one percent reduction in the update factor for urban and rural hospitals will cut another \$47 million.

As regards the reduction in the update factor, we particularly object to the Administration's abandonment of OBRA-90's commitment to eliminate the urban-rural payment differential by FY 1995.

- o We are concerned about the Administration's proposed cuts in indirect and direct medical education. The proposed budget would reduce medical education spending \$5.22 billion over the next five years. We believe it would be unwise to make a decision to reduce these payments at this time as the Congress and Administration are poised to consider major health care reform initiatives which will likely have profound implications for our nation's teaching hospitals. Any such spending changes should only occur in the context of health care reforms. We are also aware that this subcommittee has consistently revealed its sensitivity to the difficulties confronting teaching hospitals through its rejection of the prior administration's budget proposals to cut indirect medical education payments. We urge the same treatment for this budget proposal as well.
- o As regards the proposed cuts in direct medical education, the Health Care Financing Administration (HCFA) has indicated that by using a national average per resident amount, instead of a hospital specific per resident amount, the current "inequities" will be resolved. The estimated impact of this proposed change on California hospitals, especially safety-net institutions, could be significant. For example, three hospitals in the Los Angeles County health system alone could lose \$1.3 million in FY 1994. In addition other major county hospitals will be severely impacted in FY 1994, including San Bernardino County Medical Center (\$339,000), San Joaquin General Hospital (\$268,000), and Santa Clara Valley Medical Center (\$328,000).
- o When inpatient capital payments were moved to a prospective payment system, hospitals were told that after FY 1995, the OBRA-90 mandated 10 percent discount in inpatient capital payments would expire and hospitals would then be paid the full update. The Administration proposes to alter this commitment - proposing instead to make the 10 percent discount permanent. This adds to the growing list of broken promises the federal government has made to our nation's hospitals.

Mr. Chairman and members of the subcommittee, it is clear that California hospitals will be expected to share a substantial part of health care reform's "sacrifices" even as we are being required to make a significant contribution to deficit reduction. However, hospitals are already making a significant contribution to our communities' charity and uncompensated health care needs. In addition to covering Medicare and Medicaid shortfalls, which accounted for nearly \$3 billion of California hospitals' uncompensated care costs in 1992, another \$1.4 billion in uncompensated care was provided in the form of charity and bad debts. Additional Medicare and Medicaid hospital spending reductions without the relief of health care reform will only add to this steadily increasing burden.

During the past decade, California hospitals have made great strides in achieving more efficient and cost effective use of hospital services. Hospital expenses per capita ran about 10 percent higher in California than the nation from 1957 through 1982. This difference narrowed to 5 percent in 1983, and between

2 and 3 percent from 1984 to 1987. By 1992, California per capita hospital expenses were 7 percent less than the national average. Changes in medical treatment and technology have resulted in a significant volume of patient care being shifted to less expensive outpatient services during the past decade. Outpatient visits have increased by 50 percent since 1980.

The average length of stay in California hospitals dropped from 6.6 days in 1987 to 6.2 days in 1992. During 1990 California's average length of stay was a full day shorter than the national average: 6.2 days versus 7.2 days.

California hospitals admissions have been sharply reduced from 132 admissions per 1,000 population in 1980 to nearly 100 admissions per 1,000 population in 1992. During the latest year for which there is comparable data, 1990, California's admission's per 1,000 population was nearly 18 percent below the national average: 103.2 admissions per 1,000 population versus 125.8 admissions per 1,000 population

Hospitals share expensive technology and services whenever possible to reduce health care costs, increase efficiencies, eliminate duplication of services and improve quality.

If the proposed Medicare reductions are enacted, California hospitals will be caught in the price vise as they are required to pay higher prices for drugs, utilities, labor, insurance and other products and services while receiving less revenue to cover increasing costs that are beyond their control. The March 1, 1993, Prospective Payment Assessment Commission (ProPAC) report to Congress states that, "The two largest components of hospital cost increases were economy wide price inflation and changes in the mix of cases treated, both of which are generally viewed as beyond the hospital's control. These two components accounted for almost 60 percent of the rise in hospital costs during the study period of 1985 to 1989."

Some of the explanatory factors behind health care cost inflation include:

- o **Labor Costs** - Labor related expenses comprise more than half of the average hospital's total operating costs. Hospitals are more labor intensive than any other industry. Labor expenses per patient day in California in 1990 equalled \$636. The rate of increase has been progressing since 1988 at more than 9 percent per annum. The U.S. average of labor expenses per patient day in 1990 was \$483. California's labor expenses per patient day are higher than the national average because California hospitals have a lower admission rate, a lower length of stay and do business in a geographic location with higher general wage levels than the national averages. The lower admission rate and length-of-stay means that California hospitals treat a "sicker" patient than the typical hospitals. The higher severity level requires a higher skilled labor mix.
- o **Cost of Supplies and Drugs** - Health care costs in the hospital are driven significantly by the cost of supplies and drugs necessary to provide quality patient care. During 1992, the cost to hospitals for necessary medical/surgical supplies rose 7 percent and are projected to increase another 6.5 to 7 percent during 1993. The prices hospitals must pay for pharmaceutical products soared 22 percent in 1992 and a 15 percent hike is expected in 1993. A study by ProPAC found that pharmaceutical products contribute more to hospital-specific inflation than all other goods and services purchased by hospitals combined. A General Accounting Office (GAO) study of the 29 most widely used prescription drugs found that most of their prices doubled, and some quadrupled, between 1985 and 1991.

- o **Malpractice Insurance** - The average payment in malpractice awards is \$1.7 million per claim. Even more expensive is the cost of defensive medicine. The practice of performing tests and procedures primarily out of concern over potential malpractice liability now costs more than \$20 billion a year in the U.S.
- o **Administrative Costs** - Government rules, regulations and mandates account for an incredible amount of documentation and paperwork by hospitals. More than 25 percent of the health care premium dollar is consumed by insurance companies, administrative expenses and costs incurred to comply with government regulations and documentation requirements.
- o **Medical Waste Disposal** - Additional regulations for medical waste disposal has boosted some hospitals' expenses for managing waste by as much as 400 percent in the past few years. At least five federal agencies have authority over and are actively involved in regulating health care medical waste management activity.
- o **Cost of Utilities** - Hospitals are large consumers of energy, especially electricity, natural gas and water. Since 1987, hospital costs for energy have risen by more than 20 percent. Many local governments now impose an energy consumption tax to raise revenues to relieve stressed local budgets. Some hospitals report increased costs up to \$200,000 annually due solely to locally imposed energy resource consumption related taxes.

It is also important to highlight the costs of AIDS treatment. More than a decade into the AIDS epidemic, the total number of cases continues to grow, affecting all segments of the population. By December 1993, cumulative U.S. AIDS deaths will rise to more than 160,000. In California, more than 35,000 people will have died from AIDS by the end of 1993. DHHS estimates lifetime costs of health care at more than \$100,000 for individuals who are diagnosed this year.

The threat of antitrust action often impedes hospitals from pursuing joint efforts. Thanks to Chairman Stark's continued interest in this issue, hospitals have made progress in sending the message to Congress and the administration that hospitals struggle with mandates from the Department of Health and Human Services to achieve efficiency, while simultaneously the Federal Trade Commission and the Department of Justice impedes collaborative activities which may achieve this goal.

With respect to the larger issue of health care reform and how cost containment is best achieved, California hospitals support the development of an effective universal health insurance program that provides medically necessary health care to all American residents. The only viable long-term way to expand access and contain costs is to change the fundamental way in which health care services are organized and delivered. Short-term budget cuts will not address the underlying problems nor produce balanced incentives for health care providers and other stakeholders. Much of what passes for cost containment is simply cuts in provider payments.

We are concerned about a recent press report that the President's Task Force on National Health Care Reform is considering three short-term price control options as necessary to restrain health care spending. Option 1, a freeze on prices charged by providers and by certain suppliers, while sounding simple raises serious and complex questions. For instances, would providers input prices also be frozen, e.g., essentially an economy wide price freeze for health care related labor, supplies and equipment? It is important to understand that California hospitals have labor contracts, new environmental and other regulatory requirements, utility contracts,

purchasing agreements for supplies and services, and other obligations which involve costs, and therefore price increases. Without a corresponding input price freeze hospitals would be forced to absorb their input price increases with potentially disastrous results. Another question would be how even a short-term price freeze would allow hospitals to recover all or part of their steadily increasing costs of uncompensated care? A price freeze will not change the current local situations in which more and more uninsured patients and undocumented immigrants enter our emergency rooms every day.

Option 2, caps on insurance carriers, raises the same issues as Option 1 but played over a slightly delayed scale. The first squeeze on carriers will ultimately result in the potential hospital distortions mentioned above. Option 3, extending Medicare's DRG pricing payment program to hospitals will freeze the status quo, could impede progress on health care reform and create many of the potential problems noted above. Again, while sounding simple, this option has many serious questions, one being, whether all payers are required to pay Medicare prices?

Clearly health care reform is needed and California hospitals support fundamental, systemic changes in the financing, payment and delivery systems. Only through structured changes can universal access and economic discipline be achieved. Caution must be exercised to avoid short-term quick-fix ideas that may be appealing but, in fact, are fundamentally complex with severe adverse potential consequences for patients and 'hospitals.

We support universal access, a uniform benefit package, underwriting reforms, balanced incentives among the stakeholders, employer coverage of employees, purchasing for small groups and economic discipline through capitation payments to integrated health care delivery systems or networks.

Health care reform is not just cost containment. Inequities in federal price control policies affect patients, institutions and regions of the country differently. The national DRG rating system, for example, has hit California hospitals hard, having a particularly adverse impact on rural and Medicare dependent hospitals.

Mr. Chairman and members of the subcommittee, I want to reiterate that while California hospitals are ready to stand up with you in pursuit of meaningful health care reform, we are concerned about additional spending reductions which do not appear to compliment health care reform and that may, instead, adversely impact hospitals' abilities to continue to provide quality patient care or access to all patients.

Thank you.

Mr. LEVIN. Thank you very much.
Mr. Yarwood.

**STATEMENT OF BRUCE YARWOOD, LEGISLATIVE COUNSEL,
AMERICAN HEALTH CARE ASSOCIATION, ACCOMPANIED BY
ROBERT DEANE, CHIEF ECONOMIST**

Mr. YARWOOD. Mr. Chairman, thank you. My name is Bruce Yarwood. I represent the nursing home industry, the American Health Care Association, and I appreciate you bringing us to the table with the hospitals. Thank you. We are normally the ones that are sitting on the left side.

We are here today to kind of defend ourself and dust off our defense of the return-on-equity provision that we have seen over the past 5 or 6 years.

As all of the speakers have said prior, we, too, have the concern over major health care reform coming down, especially long-term care, and at the same time trying to tinker with the system right now by pulling out return on equity, and restricting our ability to continue to grow.

As the man from New York said, if we take the capital out of the system, we really hurt ourselves.

I would suggest two or three things in thinking about the return on equity and our opposition. First, it has been said that this is the profit item. We are the only industry that has that profit item. Yet, we are the only industry that has a system that is retrospective, not prospective. We are suggesting in the long term that we go prospective, and that we don't tinker with the system right now. As soon as the prospective system goes into gear, this return-on-equity issue won't be an issue anymore.

The second thing I would suggest is that this year's budget proposal comes with the thought that we level the playing field between the proprietary and nonproprietary nursing homes. I would suggest to you that there are advantages on the nonproprietary side that we don't have in terms of accessing the capital market, such as tax benefits, and also an ability to create bonds and do some of those things that we don't have the ability to do.

I would say a third thing in defense of ourself. We do have access to the private marketplace to find additional capital and to fund that capital without the use of the return on equity, causing interest rates to rise, and that cost gets fed right back into the system, and this fact alone will immediately erode that savings figure.

We are suggesting that the savings figures are probably erroneous. Second, this issue has been dealt with and rejected before, I think, over the past two or three Congresses. We would continue to do so.

We also recognize that you will be voting on a budget mark today. We would suggest some other things to look at.

At the risk of Duane slapping me across the head and shoulders, we would suggest a couple of things that might deal with the hospital system. We have historically been talking about leveling, the technical term, the 223 limits. We find in some recent data coming out HCFA that there is not a lot of difference in terms of the patient care needs of hospital distinct parts and freestanding nursing homes, yet, the hospital distinct parts have a tremendous advan-

tage in terms of reimbursement over the freestanding. We would suggest leveling those. We are not suggesting bringing hospitals down or us up. We would suggest a level in terms of averaging. We approximate an \$80 to \$85 million savings.

We would suggest also that we zero in on our patient mix of today. What we find is that the acuity of our patients is becoming much more difficult. We think that we can move into what we call a subacute area—I think California has a subacute definition—the State of Illinois has a subacute definition—where we would be taking some of the patients that have a subacute definition in the hospitals.

If we run some quick calculations for just room and board by averaging the subacute DRGs, we find significant savings, from the standpoint of us taking care of that type of patient versus a hospital taking care of the patient.

I see Mr. Cardin walked in. I would move to the fourth area.

We would love to work with a PPS system in the future, as the State of Maryland has.

Mr. CARDIN. Great.

Mr. YARWOOD. We will jump all over that right now.

Mr. CARDIN. Great.

Mr. YARWOOD. So, we would say in summary is that we would suggest a prospective system. In going to prospective system, we think that the pulling out of return on equity provision is not the way to go. There are some ways to supplant that savings by looking at other ways and to other things in the system.

I will take the offer also that you made in terms of, do we like wage and price controls. We would probably be hurt significantly—not probably—we would be hurt significantly.

First of all, we are operating on about a 2 to 2½ to a 3 percent profit margin, pretax. If we just put a price control over 2 years in a marketplace that is that thin without dealing with the controls of the cost factors, such as wages, and we are two-thirds labor intensive, such as variable mortgages and things of that nature, we get squeezed real fast. We are in an industry where two-thirds of our patients are Medicaid—very controlled—very controlled Government operation in terms of the Medicaid cost. So we would have a very difficult time.

I see the red light.

I would also suggest that in listening to the ProPAC discussion and seeing the type of issues that ProPAC is moving into, an awful lot of those are nursing home industry issues. We suggest that we look at the ProPAC group and potentially try to expand that group and bring some people other than from the hospital system onto ProPAC.

With that, I thank you very much.

[The prepared statement follows:]

TESTIMONY
BY
BRUCE YARWOOD
LEGISLATIVE COUNSEL
AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman, members of the Committee, I am Bruce Yarwood, Legislative Counsel for the American Health Care Association (AHCA). I want to thank you for the opportunity to testify on the major concerns specifically related to Medicare Part A of AHCA, a national, nonprofit trade association representing over 11,000 nursing facilities and long term care providers which care for more than one million residents.

As the 103rd Congress unfolds and the Ways and Means Health Subcommittee begins to examine proposals for both economic and health reform, we ask that you consider our views in the context of cost containment, access, and quality of care. We can certainly appreciate your need to look at the President's proposals for health care cost reductions. We support positive efforts to do so, but with the caution that proposed budget reductions be viewed in context with proposed health care reform. In other words, we don't believe it's appropriate to make decisions today regarding costs, rates, and programs, and then in a few months come back and rearrange the entire health care delivery system for long term care. AHCA has formulated a long term care financing policy which is progressive yet fiscally responsible, relies on a private/public partnership, and emphasizes private responsibility.

As you would expect, we do have a few concerns about the Medicare Part A budget proposal before you. We also have some suggestions that might be appealing to you. Let me address both.

RETURN ON EQUITY

President Clinton's economic plan contains a provision which would eliminate RoE payments to proprietary skilled nursing facilities (SNFs) at a savings of \$110 million in FY94. The reason stated for this elimination is that proprietary SNFs are the only category of providers that receives RoE. Nonproprietary SNFs do not receive these payments, and the contention is that elimination of the category would create fair competition.

This is ground we have covered before. In fact, the same proposal was made during previous Congresses, and was rejected. We believe it was rejected for the following reasons:

- Nursing homes are still paid on a retrospective basis for the cost of care, as opposed to a hospital prospective diagnostic related group (DRG) system.
- Return on Equity (RoE) and the allowance for interest on debt is the only payment which proprietary facilities receive on their capital investment in the physical plant of the facility. To eliminate RoE would reduce the industry's ability to affect private capital and increase the reliance on government funding at a time of increased demand for nursing home beds.
- This elimination would have a dramatic effect on access to long term care services. Projected growth in the elderly population in the United States during the next several decades is extremely well-documented as the "baby boom" generation grows older and life expectancy continues to increase. For example, the Urban Institute has reported that the number of frail elderly can be expected to more than quadruple within the next four decades. Congress must ensure that long term care services will be available to meet the tremendous increase in demand in the foreseeable future.
- The "Pepper Commission" report and a series of other similar reports illustrate the serious concern about access to long term care. Occupancy rates for nursing facilities in almost all states exceed 90 percent and waiting lists for beds are the norm rather than the exception. It is very short-sighted for the government to eliminate incentives that encourage participation in the Medicare program and private sector growth when the government is struggling to find solutions to meet the growing demand in long term care.
- This proposal would not have the effect of "leveling the playing field" regarding capital acquisition between proprietary and nonproprietary nursing facilities because the non-proprietary facilities already have

unique financial opportunities that are justifiably unavailable to proprietary facilities, such as lower interest rates through government subsidized loans, and relief from paying certain property taxes.

- The Congressional Budget Office (CBO), along with the "Pepper Commission" projects an increase in the demand for skilled beds. An RoE payment provides equity capital to help build new beds to meet this increased demand. Without the incentives, supply will stay stable, and demand will increase with the results being a price and cost increase to Medicare.
- President Clinton's economic plan reportedly contains a provision which would eliminate RoE payments to proprietary SNFs. This is the only profit opportunity available to proprietary nursing home owners who provide Medicare skilled nursing services and is counter to other private sector initiatives contained in the President's package that encourage investment. Until a prospective payment system is instituted that rewards cost-effective operations, this elimination would cause a hardship on many facilities that operate on thin profit margins (according to "The Guide to the Nursing Home Industry" published by Arthur Andersen, the profit average for all nursing homes was 2.83 percent in 1990).
- In the long run, to cut RoE will cause a replacement of equity with debt which costs more. This in turn will be a cost to the Medicare program.
- To pull a small piece out of a complex reimbursement system such as the one for SNFs seem counterproductive. We have always agreed to setting up a prospective system, with other various incentives, to eventually replace RoE. To do so piecemeal is counterproductive.

In short, this is a proposal that has been dusted off in a search for "savings." It has been shown by the committee to be overstated, counterproductive, and not useful. It is a short-sighted gain that can haunt further budgets when government programs will be demanded to meet the needs of a growing elderly population. We again urge it be eliminated from the list of cuts.

SECTION 223 MEDICARE LIMITS

There are other areas that can provide the Medicare program with savings. We have consistently suggested that Congress consider "leveling the playing field" between hospital-based and free-standing providers of skilled nursing care of like patients under Section 223 Medicare Limits. This not only acts as an incentive for nursing facilities to take these patients, but more importantly, allows for more cost effective care.

Currently, Congress sets the reimbursement limits for hospital-based SNFs at 50 percent of the difference between 112 percent of the hospital-based mean and 112 percent of the free-standing SNF mean. The national Medicare routine cost limit differential between these hospital "distinct parts" and free-standing SNFs is an estimated \$45 per day. In addition, hospital-based SNFs receive administrative and general add-ons that are not available to free-standing SNFs. We calculate that eliminating the differential would represent a net savings of over \$80 million if the maximum hospital rates were to be leveled with the maximum free-standing SNF rate to around \$125 per day. This occurs by averaging both rates.

AHCA believes that the recent Health Care Financing Administration study, done for the General Accounting Office on the relative acuity of Medicare patients in hospital-based and free-standing SNFs reinforces the fact that the current differential between the two is uncalled for and a waste of Medicare funds. Specifically, it provides evidence that the differential allows the hospital-based SNF to care for the same patients as the free-standing SNF at significantly higher rates and provides an opportunity for hospitals to cost-shift from the flat rate diagnostic related group to cost-reimbursed SNF care.

Thus, Medicare reimbursement differentials between hospital-based distinct part and free-standing SNFs encourages

inefficient utilization of resources. In the current era of cost containment, the Medicare program should provide incentives for patients to be serviced in the most cost effective setting, rather than provide incentives for patients to be served in more costly hospital-based SNFs. Therefore, AHCA believes that the competitive playing field between hospital-based and free-standing facilities should be leveled and that all SNFs should be subject to a single set of payment limits.

SUB-ACUTE BENEFIT

Another area that needs to be investigated is the development of a sub-acute level of care under Medicare Part A to provide intensive skilled nursing care. Currently, there are many "heavy-care" elderly patients who are unable to get into nursing facilities because of inadequate payment by Medicare. Medicare currently provides only one nursing facility reimbursement rate for all patients, creating a disincentive for serving "heavy-care" patients.

In 1990, the Department of Health and Human Service (HHS) reported to Congress that the problem of "boarding" the elderly affects about 25 percent of the nation's nearly 6,000 hospitals and that urban hospitals are the most effected. The study, which was based on 1985 data, estimated the cost to hospitals at \$420 million a year and health analysts say the problem has grown since then.

Because of this dilemma, AHCA has developed a concept for a sub-acute level of care within Medicare for consideration by Congress which maintains the principles of cost containment, access, and quality of care. We believe such a level of care should have at least the following features:

- Rates should be developed, with criteria modeled after existing state (e.g., California/Illinois) sub-acute programs. Patient types suggested include:
 - tracheotomy patients
 - ventilator patients
 - I.V. therapy patients
 - head trauma patients
 - wound care patients
 - pain management patients
 - antibiotic therapy patients
 - renal dialysis patients
- Medicare should provide reimbursement for the entire length of stay during which the patient continues to need this sub-acute level of care.
- The routine cost limit should be raised for facilities in the sub-acute program.
- Facilities must be "designated" by Medicare for participation in this program, and must agree to accept patients who qualify for this level of care.

Analysis has shown that participation of the nursing facility industry in the sub-acute care market can produce savings of approximately \$3 billion per year in 1990 dollars, one-half of which are in Medicare/Medicaid programs. The current sub-acute industry is over \$10 billion in size and upgraded SNFs can provide care at an average of two-thirds of the cost now being experienced in hospitals.

PROSPECTIVE PAYMENT SYSTEM

As we have said many times, AHCA is supportive of the development and implementation of a case-mix prospective payment system for SNFs as mandated by OBRA 90, which maintains quality, access and provider viability. As this moves through the process, AHCA recommends that the new system include a number of features not present in the current cost-based reimbursement system:

- Patient-related costs should be reimbursed by a patient-based prospective pricing system. This system should use resident acuity data generated by the congressionally mandated minimum data set.

- Separate, per unit payment for selected special services and therapies should be included outside of the patient-based component.
- Capital payments should be based on a fair value rental approach in order to recognize the true economic costs of capital services.
- Non-patient related costs should be reimbursed prospectively on a facility-specific basis subject to a ceiling with efficiency incentive payments included.
- The threshold for participation in the prospective flat rate part of the Medicare system should be raised from 1,500 to 2,500 annual patient days.

We eagerly await the report from the Secretary of HHS on this system. We have said many times that the creation of a prospective system will allow for equal treatment among the varying levels in the continuum will increase access, and maintain cost. We will not get into skirmishes over such things as RoE, but focus on how to provide the elderly with quality care.

While getting the chance, we would be remiss if we didn't also remind the Committee of a few more issues that continually come up and could be handled in this year's reconciliation process.

ELIMINATION OF THREE-DAY PRIOR HOSPITAL STAY REQUIREMENT

We continue to support of the repeal of the Medicare three-day prior hospital stay requirement for SNF care. Proponents of the requirement argue that it serves a gatekeeping function to prevent unnecessary admissions to SNFs. However, in actuality, this requirement blocks beneficiaries' access to a legitimate level of care; namely, skilled nursing services and their associated rehabilitation services. It further leads to unnecessary hospital stays for beneficiaries whose medical needs are most appropriately and economically addressed in a SNF. And, the three-day prior hospital stay requirement offers physicians a perverse incentive to admit patients to a hospital; this must be done to qualify beneficiaries for Medicare SNF benefits even if they don't require hospital care, resulting in hospital admissions that are both clinically inappropriate and unnecessarily costly.

The major obstacle to eliminating the Medicare SNF three-day prior hospital stay requirement has been cost. We disagree with a CBO cost analysis that fails to take into adequate account offsetting savings to Medicare, by the elimination of unnecessary hospital stays. An AHCA analysis estimates that ending the three-day prior hospital stay requirement would save more than \$1 billion over five years because savings in Medicare hospital expenditures would more than offset increased SNF expenditures.

As a minimum, we ask the Committee to request HHS set up a pilot review to test our theory.

ProPAC

As health care reform becomes a reality, the Prospective Payment Assessment Commission (ProPAC) estimates and analyses are ever more present. Yet, ProPAC is dominated entirely by the hospital system and its appointments. As we move into areas of overlap and competition, it seems we also believe it is imperative that there be SNF representation on ProPAC. We request of the Committee that statutory language to designate a long term care representative to the Commission. Congress in OBRA 90 has given the Commission the responsibility to payment system comment on a SNF prospective developed by HHS. Shouldn't the nursing home industry be represented? We think so.

HOSPICE CARE

We are pleased that the recently introduced bill, H.R. 21, "Miscellaneous and Technical Amendments 1993" (Rostenkowski, D-IL) does not impose limitations on the availability of the Medicare hospice benefit in nursing homes, but we continue to be concerned about the psychological aspects of informing patients about this benefit at the time of admission.

SNF WAGE INDEX STUDY

"Miscellaneous and Technical Amendments 1993" also calls for a study of wage index. We have no objection to the collection of data on employee compensation and paid hours of

employment in SNFs, but we object to a "stand-alone" study to reverse the current payment system. The current system should not be changed, when HHS will be coming forth with a prospective payment in the upcoming months. Why spend valuable resources to change something that will most likely be reversed?

As you can tell, we are very concerned over various provisions of the law relating to long term care coverage. We have historically been a small part of the Medicare budget. Yet, we have been taught that Medicare principles govern our operation now and will do so in the future. I appreciate the opportunity to testify before the Subcommittee and will be happy to answer questions about the proposal or our concerns relating specifically to Medicare Part A.

Mr. LEVIN. Thank you.

Ms. Michael, you are accompanied by Gwen Gampel. Welcome. I also welcome Mr. Deane.

Please proceed.

STATEMENT OF MAUREEN MICHAEL, PAST PRESIDENT, NATIONAL RENAL ADMINISTRATORS ASSOCIATION, AND EXECUTIVE DIRECTOR, CENTRAL FLORIDA KIDNEY CENTER, ORLANDO, FLA., ACCOMPANIED BY GWEN GAMPEL, FEDERAL RELATIONS CONSULTANT, NATIONAL RENAL ADMINISTRATORS ASSOCIATION

Ms. MICHAEL. Thank you.

Good afternoon, members of the subcommittee. My name is Maureen Michael, and I am the executive director of Central Florida Kidney Center, which operates two nonprofit dialysis facilities in Orlando, Fla. I am also a past president of the National Renal Administrators Association.

I appreciate the opportunity to appear before the subcommittee this afternoon to discuss the ESRD-related budget issues and ask that the entire written testimony submitted earlier be entered into the record. My oral testimony will focus on two recommendations.

Mr. LEVIN. Without objection, all of your testimony will be fully incorporated into the record.

Ms. MICHAEL. Thank you.

First, we strongly recommend the subcommittee approve ProPAC's recommendations 18 and 19 which call for a 2.5-percent update to the composite rate for dialysis services in 1994 and improvement of the data quality and program administration by HCFA for dialysis services.

Concerning President Clinton's 1994 budget requests, we urge rejection of the proposal to reduce the EPO payments by \$1 per 1,000 units. We also suggest that a broader study be conducted before there is consideration in making permanent the 18-month ESRD secondary payer provision.

It will come as no surprise to you that the NRAA wholeheartedly endorses ProPAC's recommendation that both freestanding and hospital-based facilities receive a 2.5-percent update.

An update is long overdue. For 20 years, the Federal Government has essentially frozen the level of payments to dialysis facilities. Thanks in large part to the efforts of the chairman of this subcommittee, dialysis payments were increased by \$1 per treatment in 1991. Still, adjusting for inflation, dialysis reimbursement rates were nearly 65-percent lower in 1991 than they were in 1974 according to the committee's 1992 Green Book.

Now, on ProPAC's formula for updating dialysis payments, they have determined that dialysis services should receive a 2.5-percent update for all facilities in fiscal year 1994. To arrive at this recommendation, ProPAC has calculated that a market basket of the goods providers purchase to furnish dialysis services is projected to increase by 4.5 percent.

ProPAC also believes that new technologies will increase the cost per treatment by 1 percent and that dialysis facilities can only expect a 2-percent increase in productivity.

Using their own formula, they should have arrived at a 4.5-percent recommendation; the market basket at 4.5 percent, plus science technology of 1 percent, minus productivity of 1 percent brings us back to the original 4.5 percent. However, they decided to further reduce the update recommendation by 2 percent as a discretionary adjustment, primarily because of ProPAC's lack of confidence in HCFA's data. This is one area in which we would disagree with their analysis.

NRAA performed our own cost analysis of cost report data and projections, and they indicate that the projected mean 1994 blended cost per dialysis, being a blended rate of 82 percent hemodialysis and 18 percent CAPD, will be \$125.44. To arrive at the 1994 projected cost per dialysis, we used ProPAC's average annual percentage from 1989 to 1991.

When adjusted for both the additional cost of 5.1 percent, which ProPAC has accepted due to the misallocation of overhead costs attributed to EPO on the cost report, and an average additional \$3.45 for costs associated with new regulatory requirements, we conclude that the actual mean blended cost for dialysis facilities in 1994 will be \$135.13. By contrast, median payments are currently \$125 for freestanding facilities and \$130 for hospital-based facilities.

We understand that our calculations do not take into account an adjustment for the fact that cost reports used in the analysis have not been audited. While we do not know what adjustments should be made, we believe HCFA's 11.8 percent offset, which ProPAC has adopted, is too high. We are currently researching and evaluating what an appropriate audit adjustment, if any, should be.

To continue the reimbursement at the current rate will not allow the ESRD community to make needed changes. While no study has been able to conclusively link quality and cost, the Institute of Medicine has concluded that previous decreases in reimbursement may have adversely affected quality. They have recommended that the rate should be updated annually.

We would like to remind the subcommittee that no other medical providers have been forced to live without inflation updates like dialysis services. In addition, no other medical providers have less opportunity to cost shift than dialysis providers, given that on average, 90 percent of payments come from Medicare. Nor can the productivity gains of the past be replicated in the 1990s. We cannot lower our staff-to-patient ratios any further, nor can we continue to downgrade to lesser trained and less costly staff. All of the gains from reusing dialyzers have also been achieved.

We are caring for a patient population that has been on dialysis for 20-plus years and now have more comorbid conditions which require more labor-intensive care. The U.S. Renal Data System indicates that many facilities need to increase dialysis treatment times. This, too, will increase costs.

In conclusion, we again thank you for the opportunity to testify before this subcommittee this afternoon. We strongly endorse ProPAC's recommendations to increase payments to both freestanding and hospital-based facilities by 2.5 percent in fiscal year 1994. As the persons responsible for the cost reports for our dialysis facilities, we truly believe that an update is necessary in order to

cover our increasing costs and provide quality of care to our patients.

We hope that our testimony has provided you with the information you need to offer this recommendation as part of the subcommittee's fiscal year 1994 budget legislation.

At this time, I would be pleased to answer any questions you may have.

[The prepared statement follows:]

**STATEMENT OF MAUREEN MICHAEL,
EXECUTIVE DIRECTOR, CENTRAL FLORIDA KIDNEY CENTER, ON
BEHALF OF THE NATIONAL RENAL ADMINISTRATORS ASSOCIATION**

Good afternoon Mr. Chairman. My name is Maureen Michael, and I am the executive director of the Central Florida Kidney Center, Inc., which operates two non-profit dialysis facilities in Orlando, Florida. I am also a past president of the National Renal Administrators Association (NRAA). The NRAA is a voluntary organization representing professional managers of dialysis facilities and centers throughout the United States. Our members manage approximately two-thirds of the dialysis units in this country which provide dialysis services to a majority of Medicare End-Stage Renal Disease (ESRD) patients. The association was founded to provide information and education to our members and to work with the Congress, the Administration and other oversight organizations on the Medicare ESRD program.

I appreciate the opportunity to appear before the Subcommittee this afternoon to discuss ESRD related budget issues. My testimony will focus on four recommendations related to the Medicare ESRD program:

- We strongly recommend the Subcommittee approve the Prospective Payment Assessment Commission's recommendations 18 and 19, which call for a 2.5% update to the composite rate for dialysis services in 1994, and improvement of data quality and program administration by HCFA for dialysis services.
- Concerning President Clinton's 1994 Budget requests, we urge rejection of the proposal to reduce the payment for EPO by \$1 per 1,000 units. We also suggest that a broader study be conducted before there is consideration in making permanent the 18 month ESRD secondary payer provision.
- With regard to health care reform, we strongly encourage the Subcommittee to include renal related medical services and transplantation in any "standard" or "comprehensive" benefits package developed and that the Medicare ESRD program be maintained as it is currently structured.
- Lastly, we believe that the United States Renal Data System (USRDS) must be adequately funded and supported and that the contract require the collection of both cost and quality data in a format dialysis facilities can access and utilize.

ENDORSEMENT OF PROPAC 2.5% UPDATE RECOMMENDATION

It will come as no surprise to you that the NRAA wholeheartedly endorses ProPAC's recommendation that both freestanding and hospital-based dialysis facilities receive a 2.5% update in their 1994 composite rate payments.

In fact, we believe their recommendation is on the low side. This is based on our own analysis of ProPAC average cost data trended forward and modified to include some additional costs for new regulatory requirements and revision of the misallocation of overhead costs associated with EPO. However, knowing full well the cost constrained environment we are facing, a 2.5% update would be a reasonable compromise. We truly believe this increase is vitally necessary to maintain quality of care in dialysis units.

REASONS TO SUPPORT INCREASE

An update is long overdue. For twenty years the Federal government has essentially frozen the level of payments to dialysis facilities. The initial reimbursement rates for outpatient dialysis were established in 1973 and remained unchanged until 1983. The rates were lowered in 1983 and again in 1986. During this time, no adjustment was made for inflation.

Thanks in large part to your efforts Mr. Chairman, dialysis payments were increased by \$1 per treatment in 1991. Still, adjusting for inflation, dialysis reimbursement rates were nearly 65% lower in 1991 than they were in 1974, according to the committee's 1992 Green Book.

You may recall that you spoke before our annual meeting in Washington in 1990, at which time you hoped to increase payments by \$3 or \$4 per treatment. Now, we hope you will continue to support your original pledge.

By all accounts, in real dollars, payment rates per dialysis have fallen steadily over the program's history. We will also be the first to admit that some operating costs also went down during the 1970s and 1980s and we achieved some impressive productivity gains. Now however, in the 1990s we face a very different picture as ProPAC points out in their 1993 March Report to Congress.

PROPAC FORMULA FOR UPDATING DIALYSIS PAYMENTS

Using a formula similar to the one used to calculate the hospital payment update, ProPAC has determined that dialysis services should receive a 2.5% update for hospital-based and free-standing facilities in FY 1994.

To arrive at this recommendation, ProPAC has calculated that a "market basket" of the goods and services providers purchase to furnish dialysis services is projected to increase in FY 1994 by 4.5%.

ProPAC also believes that new technologies will increase the cost per dialysis treatment by 1% in FY 1994. We think that this may be low as many dialysis facilities are now faced with the need to replace older equipment with more technologically advanced high flux and high efficiency hemodialysis machines, as well as, upgrade their physical plant. While the new machines initially lowered treatment times, now treatment sessions have become both more capital and supply intensive resulting in significant increases in costs per treatment.

To further measure changes in projected costs ProPAC looked at future changes in costs attributable to improvements in productivity. Based on a Project HOPE study they concluded that the "marked productivity gains experienced in the dialysis industry through 1987 are not likely to continue." Instead, "scientific and technological advances have changed the nature of dialysis services such that only modest improvements in productivity are expected."

Realistically, the commission concluded that dialysis facilities can expect only a 2% increase in productivity in FY 1994. They believe the savings from increased productivity should be shared equally by the industry and Medicare, resulting in a productivity adjustment of 1%.

Using their own formula they should have arrived at a 4.5% recommendation (i.e. market basket 4.5% + science and technology 1% - productivity -1% = 4.5%). However, they decided to further reduce the update recommendation by 2% as a "discretionary adjustment," primarily because of ProPAC's lack of confidence in HCFA's data. This is one area in which we would disagree with their analysis.

NRAA COST ANALYSIS

Our own analysis of cost report data and projections indicate that the projected mean blended 1994 cost per dialysis (82% hemodialysis and 18% CAPD) will be \$125.44. To arrive at the 1994 projected cost per dialysis we used ProPAC's average annual percentage change from 1989-1991. When adjusted for both the additional cost of 5.1% (which ProPAC has accepted) due to the misallocation of overhead costs attributed to EPO on the cost report and an average additional \$3.45 for costs associated with new regulatory requirements, we conclude that the actual mean blended cost for freestanding facilities in

1994 will be \$135.13. By contrast, median payments are \$126 for freestanding facilities and \$130 for hospital-based facilities.

There are many costs which have only recently been incurred by dialysis facilities that are not part of the actual costs as stated in the 1989-1990 data, which ProPAC used for its analysis. Some of these costs are, but are not limited to: (1) regulatory changes, such as CLIA which will increase monitoring and testing costs for all out-patient facilities; (2) increased cost for disposal of contaminated waste; (3) state nursing practice act changes which are causing increased requirements for licensed staff as opposed to unlicensed patient care technicians; (4) increased costs associated with the recapitalization of dialysis facilities or new high flux/high efficiency dialysis equipment; and (5) increased disposable supply costs for high flux/high efficiency dialyzers and lines. Our studies indicate that regulatory compliance costs will add approximately \$3.45 per dialysis.

We understand that our calculations do not take into account an adjustment for the fact that the cost reports used in the analysis have not been audited. While we do not know what adjustment should be made, we believe HCFA's 11.8% adjustment, which ProPAC has decided to adopt, is too high. We are currently researching and evaluating what an appropriate audit adjustment, if any, should be.

In short, we believe dialysis costs in 1994 will be higher than ProPAC has projected and therefore a larger percentage update could be justified. However, we recognize the cost constraints the Subcommittee will be under this year and that the Budget Resolution will probably include a recommendation for at least \$3 billion in Medicare savings for FY 1994. Given this fact we strongly encourage the Subcommittee to support ProPAC's 2.5% increase in payments to both freestanding and hospital-based dialysis facilities.

FAILURE TO INCREASE DIALYSIS REIMBURSEMENT

To continue the reimbursement at the current rate will not allow the ESRD community to make needed changes. While no study has been able to conclusively link quality and cost, the Institute of Medicine has concluded that "previous decreases in reimbursement may have adversely affected quality." They have recommended that the rate should be updated annually.

We would like to remind the Subcommittee that no other medical providers have been forced to live without inflation updates like dialysis providers. In addition, no other medical provider has less opportunity to cost shift than dialysis providers given that on average 90% of reimbursement comes from Medicare. Nor can the productivity gains of the past, be replicated in the 1990s. We cannot lower our staff to patient ratios any further nor can we continue to downgrade to lesser trained and less costly staff. All of the gains from reusing dialyzers have also been achieved.

Also we are now caring for a patient population that has been on dialysis for twenty years and they now have more co-morbid conditions which require more labor intensive care. The United States Renal Data System (USRDS) data indicates that many facilities need to increase dialysis treatment times. This too will increase costs.

Mr. Chairman, given all of these facts we believe that a 2.5% update is a small price for Medicare to pay to help ensure that dialysis facilities can continue to provide quality care to this vulnerable population.

EPO REIMBURSEMENT REDUCTION

Included in both President Clinton's 1994 Proposed Budget and in Congressman Rostenkowski's HR 21 is a proposal to reduce Medicare's payment for EPO by \$1 from \$11 per 1,000 units to \$10 for the same number of units. We who have to purchase prescription drugs for our patients are only too aware of the high cost of drugs today. As a result, we

are very sympathetic to Congress' efforts to reduce the price of drugs.

However, we believe the current proposal is aimed at the wrong target. Providers are currently placed in an unfair bargaining position and think the fight should be between the government and the drug company. Renal administrators are not in the best position to help drive down the cost of EPO. Dialysis facilities as a condition of Medicare participation must provide EPO to patients who have prescriptions for the drug. Yet we are faced with having to purchase EPO in a monopolistic situation. Amgen is the only manufacturer of EPO and has reserved the sole right to sell EPO to dialysis facilities. Because of the monopolistic situation, we cannot invoke prudent buying principles nor will we be able to cover the cost of the drug if the reimbursement is reduced by \$1.00.

A 1990 NRAA survey found that additional personnel, supplies, billing and handling costs require facilities to have more staff on duty and to spend on average \$5.37 per EPO treatment for these items and services. This figure does not take into account additional nursing supervision of nonRN staff, additional unreimbursed lab tests, quality assurance programs, financing charges or increased bad debt.

While we recognize that providers have different purchasing powers all of us have these additional costs that the composite rate does not cover. These additional costs are not reflected in the composite rate because the formula was constructed before EPO was invented.

In addition, these costs were not included in the latest Office of Inspector General's report on the profitability of this drug to facilities.

We urge the Subcommittee to reconsider the payment reduction and find an alternative solution to reducing the cost of this drug to Medicare.

MEDICARE ESRD SECONDARY PAYER PROVISION

Included in President Clinton's proposed 1994 Budget is a proposal to make permanent the 18 month Medicare ESRD secondary payer provision instead of allowing it to expire at the end of 1995. There is also a proposal to conform the ESRD requirements to those included in the other secondary payer provisions. This would result in covering the aged and disabled with ESRD beneficiaries in the ESRD secondary payer provision and establish an employer threshold of 20 or more employees for triggering this secondary payer requirement.

The General Accounting Office (GAO) in a recent study, entitled "Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans," found a small number of beneficiaries and spouses were adversely affected by the ESRD secondary payer provision. The study concluded that a small number of beneficiaries had more difficulty obtaining a job, lost their jobs or health insurance coverage as a result of the secondary payer provision.

Unfortunately, the GAO study was based on a very limited sample and they qualified their conclusions by stating that other factors other than ESRD costs may be involved in the reported problems.

The NRAA would oppose any Medicare policy that limited access to employment or employer-based health insurance for ESRD patients. Given the inconclusive nature of the GAO study, we would urge that a broader study be conducted. This study should determine job and health insurance access problems before the Subcommittee considers making the 18 month provision permanent or extending the provision to aged and disabled ESRD patients.

President Clinton's health care reform proposal may make this issue moot. The NRAA would suggest that no action be taken until we all understand how President Clinton

intends to ensure access to health insurance for ESRD patients.

HEALTH CARE REFORM

It is our understanding that a component of health care reform will be the development of a standard or comprehensive benefit package that all plans or employers will have to provide.

While Medicare covers approximately 93% of the ESRD population, a growing number of ESRD patients are not eligible for the Medicare benefit, according to a recent Institute of Medicine Study entitled "Kidney Failure and the Federal Government." This study points out that the "absolute number of such patients has been growing, and substantial variation exists among states and major cities." They go on to say that the major non-Medicare sources for financing ESRD treatment are not adequate to meet the need of the unentitled patients. The Department of Veterans Affairs dialysis program is shrinking, the Indian Health Service faces many other demands on its limited resources, and the 19 of the 20 states that do have a state kidney disease program have benefits that vary and budgets that are not increasing. Thirty one states have no state kidney disease programs at all. With regard to Medicaid, the report states that, "Although Medicaid ESRD benefits appear to be adequate in many states, in others, they are not, as eligibility criteria and covered benefits vary widely according to state discretion."

Given the current situation there is an absolute need for ESRD treatments to be included in any health care reform benefits package. Therefore, we strongly recommend that all medically necessary renal related care be a covered benefit.

The NRAA also strongly urges that the Medicare ESRD program not be restructured as part of health care reform. If anything, the Congress and Clinton Administration should examine the Medicare ESRD program as a model for health care reform. This program has been enormously effective in terms of access to quality care, the number of lives saved and increased life expectancy. With prospective capitated payments for dialysis treatments and physician services, the ESRD program serves as a model for cost effective managed care. The ESRD program is also a first rate example of how the government, as a virtual single payer, can tightly constrain per patient costs.

The ESRD program should be studied carefully before any changes are recommended. Certainly, once health care reform is enacted and operative, we would expect the Medicare ESRD program to be re-evaluated for possible re-structuring. But for now we would not want to see changes made that could in any way affect the current access ESRD patients have to a first rate system of medical benefits.

IMPORTANCE OF US RENAL DATA SYSTEM

The United States Renal Data System (USRDS) was created in May 1988 to collect and analyze information on the incidence, prevalence, morbidity and mortality of ESRD in the United States.

To our knowledge the new contract, which is suppose to begin in July 1993, has not been awarded. As a result, all activity aside from closing the registry has been stopped.

It would be a terrible blow to patients, providers and the research community if the USRDS is not continued. Physicians and dialysis facilities are now using the data from the annual studies to evaluate their own facility's performance against the national standards for the purpose of improving quality care. This data could be utilized to help develop much needed quality standards for the industry.

The NRAA urges the Subcommittee to encourage the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to quickly award the new contract. Further, we suggest that the registry should be required to collect both cost and quality data so that

it can fulfill its legal mandate and provide the renal community the vital data it needs to promote quality care in the most cost effective manner.

CONCLUSION

Mr. Chairman we again thank you for the opportunity to testify before the Subcommittee this afternoon. We strongly endorse ProPAC's recommendation to increase payments to both freestanding and hospital-based dialysis facilities by 2.5% in FY 1994. As the persons responsible for the costs reports for our dialysis facilities, we truly believe that an update is necessary in order to cover our increasing costs and provide quality care to our patients. We hope that our testimony has provided you with the information you need to offer this recommendation as part of the subcommittee's FY 1994 budget legislation.

At this time I would be pleased to answer any questions you may have.

Mr. LEVIN. Thank you very much.
Dr. Lundin, you are last.

**STATEMENT OF A. PETER LUNDIN, M.D., PRESIDENT,
AMERICAN ASSOCIATION OF KIDNEY PATIENTS**

Dr. LUNDIN. Thank you, Mr. Chairman and members of the Subcommittee on Health.

I am pleased to be here today on behalf of the American Association of Kidney Patients. My name is Peter Lundin. I am president of AAKP and a practicing nephrologist caring for dialysis and transplant patients.

Moreover, I have been on hemodialysis myself for over 25 years and am currently the recipient of a kidney transplant.

There are three points I would like to make before the subcommittee today. First, I want to comment on the current state of dialysis treatment in the United States and to draw the necessary implications for both reimbursement policy and the need for implementation of quality standards.

Data show that dialysis patients in the United States suffer higher mortality and morbidity rates than patients in practically every other industrialized nation. All the reasons for this situation have not been identified, but it is certain that the absence of quality standards for dialysis treatments has allowed a significant decline in the duration of dialysis therapy and, therefore, the adequacy of the treatments themselves.

In addition, reductions in the availability of skilled personnel, such as nurses, social workers, and dietitians are likely a significant part of the problem. Furthermore, it is probable that reimbursement levels for ESRD in recent years in failing to meet the rising costs have also played a role in the decline in quality care.

We have through HCFA and the U.S. Renal Data Systems quantitative analyses and data directly linking outcomes such as death in dialysis patients to the amount of dialysis received. To deal with this problem, AAKP urges the subcommittee to direct HCFA, working with professional and patient communities, to develop practice guidelines leading to enforceable standards of care and regulations to assure this.

Dialysis units should then be required to comply with these regulations with appropriate penalties for noncompliance. AAKP's purpose in making this recommendation is to improve the level of care in these dialysis units, which fall below acceptable standards, rather than simply shutting them down or excluding them from Medicare.

It is time, we believe, for the Congress, HCFA, and, indeed, the American taxpayer to have the assurance that money spent on successfully extending the lives of hundreds of thousands of people with end-stage renal disease be linked with meaningful standards that not only assure a decent quality of life, but encourage and foster rehabilitation and a return to a productive normal life. Therefore, AAKP supports ProPAC's recommendation for an increase in the reimbursement rate, provided it is linked to an improvement in quality of care.

My second point addresses reimbursement for erythropoietin. AAKP remains vitally concerned about the need to assure the

availability of EPO to all kidney patients who can benefit from it. EPO has made it possible for thousands of patients to lead more normal lives and has reopened the possibility for a great many formerly debilitated patients to return to gainful productive employment.

AAKP cannot assert, however, that the proposed reduction in Medicare reimbursement for EPO will lead to decreased availability. We ask this subcommittee, nevertheless, to direct HCFA to conduct ongoing studies of the consequences of any changes in ESRD reimbursement.

Lastly, with regard to the Medicare secondary payer issue, particularly the question of whether to make the current 18-month period permanent, AAKP believes that the impact of this provision on the ability of kidney patients to obtain or maintain employment has not been fully evaluated.

The GAO study is certainly far from conclusive, but it did clearly suggest that some patients and/or spouses, however small the numbers, did experience job rejections because of health insurance costs.

The growing numbers of employable dialysis patients, a phenomenon attributable in part to the use of EPO, suggests there is a need to pay more attention to the remaining employment barriers faced by individuals with substantial health care expenses. Small employers who are most likely to provide new jobs are also the least likely under current conditions to provide health insurance coverage for any workers perceived to be disabled, particularly kidney dialysis and transplant patients.

Unless an overall national health insurance reform package can be developed that provides protection for those with high health care costs from losing or not getting jobs, we believe that making the 18-month secondary payer provision permanent at this time may have a negative impact on patient access to employment opportunities.

We respectfully suggest, therefore, that it might be prudent to delay final action on this proposal until the national health insurance reform package has been developed.

We appreciate this opportunity to address the subcommittee and will be happy to answer any questions.

Thank you.

[The prepared statement follows:]

**STATEMENT OF A. PETER LUNDIN, M.D.,
PRESIDENT, AMERICAN ASSOCIATION OF KIDNEY PATIENTS**

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE ON HEALTH I AM PLEASED TO BE HERE TODAY ON BEHALF OF THE AMERICAN ASSOCIATION OF KIDNEY PATIENTS (AAKP). MY NAME IS PETER LUNDIN. I AM PRESIDENT OF AAKP AND A PRACTICING NEPHROLOGIST. MOREOVER, I HAVE BEEN A DIALYSIS PATIENT MYSELF FOR THE PAST 25 YEARS AND I AM THE RECIPIENT OF A KIDNEY TRANSPLANT.

I WANT TO PREFACE MY REMARKS BY EMPHASIZING THAT THE MEMBERSHIP OF AAKP IS CONCERNED NOT ONLY WITH THE AVAILABILITY OF DIALYSIS SERVICES TO THOSE WHOSE LIVES DEPEND ON IT, BUT WITH THE QUALITY OF THESE SERVICES AS WELL. AS A NATIONAL ORGANIZATION OF KIDNEY PATIENTS AND PROFESSIONALS, IT IS OUR PROFOUND CONVICTION THAT CONGRESS MUST INSURE BOTH THE PROVISION OF AN ADEQUATE RATE OF REIMBURSEMENT AND THE EXISTENCE OF QUALITY STANDARDS TO GUARANTEE THE HEALTH, SAFETY AND DECENT QUALITY OF LIFE FOR ALL DIALYSIS PATIENTS.

THERE ARE THREE POINTS WE WISH TO MAKE TO THE SUBCOMMITTEE TODAY.

1. FIRST, I WANT TO COMMENT ON THE CURRENT STATE OF DIALYSIS TREATMENT IN THE UNITED STATES TODAY AND TO DRAW THE NECESSARY IMPLICATIONS FOR BOTH REIMBURSEMENT POLICY AND THE IMPLEMENTATION OF QUALITY STANDARDS.

IT IS A DEPLORABLE FACT THAT DIALYSIS PATIENTS IN THE UNITED STATES SUFFER HIGHER MORTALITY AND MORBIDITY RATES THAN PATIENTS IN PRACTICALLY EVERY OTHER INDUSTRIALIZED NATION IN THE WORLD. THE REASONS FOR THIS SITUATION ARE NOT ALTOGETHER CLEAR, BUT IT IS CERTAIN THAT THE ABSENCE OF QUALITY STANDARDS IN THE U.S., COMBINED WITH A SIGNIFICANT DECLINE IN THE DURATION AND THEREFORE THE ADEQUACY OF DIALYSIS TREATMENTS, AS WELL AS REDUCTIONS IN THE AVAILABILITY OF SKILLED PERSONNEL SUCH AS NURSES, SOCIAL WORKERS AND DIETICIANS HAVE BEEN A SIGNIFICANT PART OF THE PROBLEM. AND IT IS ALSO CLEAR THAT REIMBURSEMENT LEVELS FOR ESRD IN RECENT YEARS HAVE BEEN IMPLICATED IN THE DECLINE IN QUALITY CARE.

FOR THESE REASONS, AAKP SUPPORTS PROPAC'S RECOMMENDATION FOR AN INCREASE IN THE DIALYSIS REIMBURSEMENT RATE. AAKP IS NOT IN A POSITION TO EVALUATE IN DETAIL THE SPECIFIC AMOUNT OF THE RATE INCREASE RECOMMENDED BY PROPAC IN ITS REPORT TO THE COMMITTEE. HOWEVER, IT IS CLEAR FROM PROPAC'S REPORT AND TESTIMONY THAT PROPAC ITSELF ACKNOWLEDGES NOT ONLY A MAJOR CURRENT GAP BETWEEN COSTS AND PAYMENTS BUT THAT THE DIALYSIS INDUSTRY WILL NOT BE ABLE TO CONTINUE TO ACHIEVE THE PRODUCTIVITY IMPROVEMENTS WHICH LED TO COST SAVINGS IN PRIOR YEARS.

MOREOVER, I CAN TELL YOU THAT MANY OF THE "COST SAVING" MEASURES TAKEN BY DIALYSIS FACILITIES -- IN PART BECAUSE THE COMPOSITE REIMBURSEMENT RATE HAS NOT KEPT PACE WITH INFLATION OR RISING COSTS -- HAVE PRODUCED INCREASED INCIDENTS OF INPATIENT HOSPITALIZATION AND HAVE GIVEN RISE TO THE NEED FOR OTHER COSTLY MEDICAL TREATMENTS RESULTING FROM INADEQUATE DIALYSIS. IN SHORT, THIS SITUATION IS ESSENTIALLY COUNTER PRODUCTIVE FROM THE STANDPOINT OF COST EFFECTIVENESS FOR THE MEDICARE PROGRAM.

WE URGE THE SUBCOMMITTEE, THEREFORE, TO CAREFULLY CONSIDER THE CURRENT CIRCUMSTANCES AND PROVIDE AN APPROPRIATE RATE OF INCREASE FOR DIALYSIS SERVICES WHICH WILL ENABLE FACILITIES TO PROVIDE COST-EFFECTIVE, HIGH QUALITY CARE.

IN ADDITION, NOW THAT WE HAVE, THROUGH THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND U.S. RENAL DATA SYSTEM, DATA AND QUANTITATIVE ANALYSES DIRECTLY LINKING OUTCOMES (DEATH) TO THE AMOUNT OF DIALYSIS RECEIVED, AAKP URGES THE SUBCOMMITTEE TO DIRECT HCFA TO DEVELOP ENFORCEABLE QUALITY OF CARE AND OUTCOME REGULATIONS. DIALYSIS UNITS SHOULD BE REQUIRED TO COMPLY WITH THESE REGULATIONS AND APPROPRIATE PENALTIES FOR NONCOMPLIANCE SHOULD BE EMPLOYED. AAKP'S PURPOSE IN MAKING THIS RECOMMENDATION IS TO IMPROVE THE OUTCOMES OF DIALYSIS UNITS RATHER THAN SIMPLY SHUTTING THEM DOWN OR EXCLUDING THEM FROM MEDICARE. BUT IT IS TIME, WE BELIEVE, FOR THE CONGRESS, HCFA, AND INDEED THE AMERICAN TAXPAYER, TO HAVE THE ASSURANCE THAT THE MONEY SPENT ON SUCCESSFULLY EXTENDING THE LIVES OF HUNDREDS OF THOUSANDS OF PEOPLE WITH END-STAGE RENAL DISEASE IS LINKED WITH MEANINGFUL STANDARDS THAT NOT ONLY ASSURE A DECENT QUALITY OF LIFE BUT ENCOURAGE AND FOSTER REHABILITATION AND A RETURN TO PRODUCTIVE NORMAL LIFE.

2. MY SECOND POINT ADDRESSES THE ISSUE OF MEDICARE REIMBURSEMENT FOR ERYTHROPOIETIN (EPO). AAKP REMAINS VITALLY CONCERNED ABOUT THE NEED TO ASSURE THE AVAILABILITY OF EPO TO ALL KIDNEY PATIENTS WHO CAN BENEFIT FROM

IT. EPO HAS MADE IT POSSIBLE FOR THOUSANDS OF PATIENTS TO LEAD MORE NORMAL LIVES AND HAS REOPENED THE POSSIBILITY FOR A GREAT MANY FORMERLY DEBILITATED PATIENTS TO RETURN TO GAINFUL, PRODUCTIVE EMPLOYMENT. WHILE AAKP CANNOT ASSERT THAT THE PROPOSED REDUCTION IN MEDICARE REIMBURSEMENT FOR EPO WILL LEAD TO DECREASED AVAILABILITY, WE ASK THE SUBCOMMITTEE TO REMAIN SENSITIVE TO THIS ISSUE. AT THE VERY LEAST, WE ASK THE SUBCOMMITTEE TO DIRECT HCFA TO CONDUCT ONGOING STUDIES OF THE CONSEQUENCES OF ANY CHANGES IN EPO REIMBURSEMENT.

3. LASTLY, WITH REGARD TO THE MEDICARE SECONDARY PAYOR ISSUE, PARTICULARLY THE QUESTION OF WHETHER TO MAKE THE CURRENT 18 MONTH PERIOD PERMANENT, AAKP BELIEVES THAT THE IMPACT OF THIS PROVISION ON THE ABILITY OF KIDNEY PATIENTS TO OBTAIN OR MAINTAIN EMPLOYMENT HAS NOT BEEN FULLY EVALUATED. THE GAO STUDY WAS CERTAINLY FAR FROM CONCLUSIVE, BUT IT DID CLEARLY SUGGEST THAT SOME PATIENTS AND/OR SPOUSES, HOWEVER SMALL THE NUMBERS, DID EXPERIENCE JOB REJECTIONS BECAUSE OF HEALTH INSURANCE COSTS.

THE GROWING NUMBERS OF EMPLOYABLE DIALYSIS AND TRANSPLANT PATIENTS--A PHENOMENON ATTRIBUTABLE IN PART TO THE USE OF EPO--SUGGESTS THERE IS A NEED TO PAY MORE ATTENTION TO THE REMAINING EMPLOYMENT BARRIERS FACED BY INDIVIDUALS WITH SUBSTANTIAL HEALTH CARE EXPENSES. SMALL EMPLOYERS WHO ARE MOST LIKELY TO PROVIDE NEW JOBS ARE ALSO THE LEAST LIKELY, UNDER CURRENT CONDITIONS, TO PROVIDE HEALTH INSURANCE COVERAGE FOR ANY DISABLED WORKERS, PARTICULARLY KIDNEY PATIENTS. UNLESS AN OVERALL NATIONAL HEALTH INSURANCE REFORM PACKAGE CAN BE DEVELOPED THAT PROVIDES PROTECTION FOR THOSE WITH HIGH HEALTH COSTS FROM LOSING OR NOT GETTING JOBS, WE BELIEVE THAT MAKING THE 18 MONTH SECONDARY PAYOR PROVISION PERMANENT AT THIS TIME MIGHT HAVE A NEGATIVE EFFECT ON PATIENT ACCESS TO EMPLOYMENT OPPORTUNITIES. WE RESPECTFULLY SUGGEST, THEREFORE, THAT IT MIGHT BE PRUDENT TO DELAY FINAL ACTION ON THIS PROPOSAL UNTIL THE NATIONAL HEALTH INSURANCE REFORM PACKAGE HAS BEEN DEVELOPED.

MR. CHAIRMAN, WE APPRECIATE THIS OPPORTUNITY TO ADDRESS YOUR DISTINGUISHED SUBCOMMITTEE. I WILL BE HAPPY TO ANSWER ANY QUESTIONS. THANK YOU.

Mr. LEVIN. Thank you very much.

Mr. Thomas, would you like to proceed?

Mr. THOMAS. Just to partially react to your statements, Dr. Lundin.

I don't know that it is wise to wait until the overall package comes out to determine whether or not we are going to be better off because, as you are discussing quality to a very great extent—I mean you can't link them completely—but, to a certain extent, quality is tied to dollars, and the difficult part about this process of examining what we are going to do in the area of health care is to deal with large numbers of people who are relatively healthy and talk about increased exposure, that is, less insurance for more money, and at the same time focus on putting more money in particular programs that will give us slightly better quality or more coverage, and that is going to be one of the more difficult things that we are going to be faced with because we are going to be creating winners and losers, as you inevitably do when you set up a program. We are going to try not to pit groups against groups. That is absolutely the wrong thing to do.

I think all of us have to be sensitive about the difficult job in front of us, and I don't know tomorrow if for particular groups it is going to be better than today. Just let me say that.

For California and New York, because obviously an enormous amount of money is going to be wrapped up in California and New York, can you say anything in terms of whether or not we could put in place some structures, short of cost-containment arrangements or price controls, that can give us some assurance that we can get on top of this problem? Are there any experiences in either of your States that can give us some reassurance that we aren't going to have to include some kind of caps or controls?

Mr. RASKE. Let me take that, Mr. Thomas, first from a New York point of view, and that is that in New York State there is a rate-setting mechanism that is in place. So there is no possibility that shortfalls from the Medicare program will be pushed onto the private sector.

That means, however, to follow the logic through, it drives right to the bottom line of the institutions. So what this committee does and your colleagues in the Senate and the administration do has a direct impact on the operations of hospitals in New York State.

Mr. THOMAS. And that is not the case in California?

Mr. RASKE. No.

Mr. DAUNER. Congressman Thomas, as you know, any short-term scoring has to come from cuts made in payments. There is nothing that can be done on the delivery side immediately to account for savings which can be scored.

Now, things have been done, and, in fact, delivery systems are evolving in our State which are based upon risk-oriented managed care. Capitated contracts are growing rapidly. They significantly change the incentives and, therefore, the consumption of resources, especial hospital services. As that reduction occurs, then cost savings occur and the rate of increase is reduced as well.

Mr. THOMAS. Thank you, Mr. Chairman.

Mr. LEVIN. The bells did ring. But let me just ask you, in California what has been the rate of increase in hospital care? What has been the inflation factor? Do you know?

Mr. DAUNER. Yes. For the past 5 or 6 years, the per capita increase has averaged less than 7 percent in total expenditures. When you consider only the inpatient hospital component, it drops 2 percentage points below that.

Mr. LEVIN. How about overall health care costs? Do you know?

Mr. DAUNER. Overall per capita health care costs in the State have been rising at about $8\frac{1}{2}$ to $9\frac{1}{2}$ percent. Part of that is due to immigration coming into the State, both documented and undocumented immigrants, and part of the increase relates to technology, population changes, and the creation of new delivery systems and how they ultimately play out. But the efficiency of delivery is increasing rapidly.

Mr. LEVIN. All right.

Mr. Andrews has asked that he be allowed to submit some questions, and that will be granted.

The bells have rung, and I think we have a series of votes. So I think with that, if there are no other colleagues who want to submit questions for the record, my guess is we will be seeing much of each other these next few months, and we appreciate your coming here today.

With that, we stand adjourned.

[Whereupon, at 1 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

WRITTEN
TESTIMONY
OF THE
AMERICAN NEPHROLOGY NURSES' ASSOCIATION

The American Nephrology Nurses' Association (ANNA) is the professional organization representing registered nurses specializing in the care of patients with end-stage renal disease. Nearing our 25th year as a professional society and representing over 8000 members, ANNA has consistently provided relevant information on the ESRD program since the inception of the program in 1972.

The ESRD program now provides treatment coverage for more than 150,000 dialysis and transplant patients. Total program costs exceed \$5 billion annually, but these costs are directly related to the increasing number of patients initiating treatment each year. (1991 estimated data indicates more than 45,000 new patients started therapy that year.)

Unlike other Medicare funding where reimbursement has been adjusted to reflect inflationary costs, funds for the ESRD program have been reduced 3 times over the past decade (1983, 1986 & 1987, via Graham-Rudman). Only after years of successful lobbying efforts by all members of the renal community did the program receive a dismal increase of \$1²⁰ per treatment in 1991.

• **ESRD Annual Update**

As the professional association representing nephrology nurses who provide direct care for this patient population, it is our responsibility to assess the changing needs of the patients within our care. Our members have stressed the critical situation that now exists in most outpatient dialysis settings. The current reimbursement rates and inflation have made it difficult to continue providing quality care to an aged more complicated patient population. As recommended in the NAS/IOM study, "Kidney Failure and The Federal Government," the composite rate for dialytic treatment should be "updated yearly, as in the practice for the rest of Medicare."

In The Omnibus Budget Reconciliation Act of 1990, Congress asked the Prospective Payment Assessment Commission (ProPAC) to conduct a study to determine the costs, services and profits associated with dialysis treatment facilities.

In its March 1, 1993 annual report to Congress, ProPAC recommended the composite rate payment for dialysis services should be updated by 2.5% for FY '94. This recommendation is based on:

- a projected increase in the market basket for dialysis services at 4.5%;
- a +1% to reflect costs associated with scientific and technological advances;
- a -1% to encourage productivity; and,
- a discretionary 2% adjustment to "reflect the relationship between payments and estimated FY '93 costs."

ANNA supports the factors defined above upon which the update is based except for the discretionary adjustment. Audited cost reports do not reflect costs now incurred by dialysis facilities to comply with OSHA bloodborne standards and the newly implemented CLIA regulations. CLIA regulations now require increased monitoring and testing costs to meet quality assurance requirements. As dialysis clinics are considered a setting where bloodborne diseases can be prevalent, adherence to OSHA guidelines, in particular waste removal, has increased operating costs.

Dialysis facilities have been forced to implement cost-saving measures due to restricted reimbursement and inflation. The labor component of the dialysis service was often targeted. Facilities continue to substitute unlicensed personnel for registered nurses.

The patient population now presenting for dialytic treatment is more aged and medically unstable than in prior years. Any additional changes of this type in the labor force will place the patient at risk for numerous complications, both technical and medical, as well as hospitalization.

The perception that chronic renal failure patients who receive outpatient dialysis therapy are stable and treatments uncomplicated is both dangerous and unsubstantiated. Patients require at least direct supervision of unlicensed personnel by registered professional nurses.

ANNA is sensitive to the need to decrease the federal deficit and reduce excessive health care spending. However, we strongly believe that a rate increase, as recommended by ProPAC and NAS/IOM is needed to insure quality health care for these beneficiaries and reduce the potential risk of increased morbidity and mortality.

- **Setting EPO payment at \$10.⁰⁰ per 1000 units of EPO.**

This proposal had been put forth last year with the anticipated savings to be used to extend coverage for immunosuppressive therapy post transplantation. ANNA encouraged the extension of immunosuppressive coverage and still believes that this extension is needed if graft failure due to non-compliance is to be resolved. Too often, patient non-compliance is due to inability to afford prescribed medications. In too many incidents, patients must decide on buying medications or paying for basic needs such as food, clothing or housing for their families.

The proposed reduction in EPO payments in the President's budget is based on a perception that costs are well below the Medicare payment rate. However, this perception is invalid because most facilities can not negotiate the required volume discounts given the reality of a single manufacturer and the classification of EPO as an orphan drug.

Therefore, ANNA recommends that no further cuts be made to the end stage renal disease program, such as the proposed reduction in EPO payment, without a comprehensive evaluation of the potential effects of any such changes in reimbursement on patient outcomes.

- **Extending provision requiring secondary payment for certain Medicare beneficiaries with End Stage Renal Disease (ESRD).**

Under current law, Medicare is the secondary payor for ESRD beneficiaries with coverage through group health plans. Medicare makes secondary payments for the first 18 months of entitlement, after which Medicare becomes the primary payor.

ANNA supports that this provision be made permanent and that consideration be given to extending the secondary payor provision to 24 months. This extension would provide additional savings to Medicare that could then be used to offset the costs of the composite rate update.

The GAO study, Medicare ESRD Expenditures, Extending Medicare Secondary Payor Provision, states that this provision has shifted "slightly more than 1%" of the total Medicare expenditures spent in 1989 for beneficiaries with ESRD. The report finds the amount of this cost shifting to be relatively small. Given the data analyzed by ProPAC on cost shifting under PPS, this amount is not near the magnitude of cost shifting seen elsewhere within the PPS.

The report further states that the number of beneficiaries affected was small because of the relatively small numbers of patients who seek employment or are employed. Data from the HCFA shows that the mean age of the patient now initiating dialysis is 62 and that the greatest increase in new cases is for patients 65 years or older (P. Eggers, 1991). Therefore, most patients now initiating therapy are either retired or approaching retirement and not seeking employment.

The end stage renal disease program has remained a success, in part, due to the commitment by Congress to assure quality patient care. As Congress debates a new health care reform proposal, we believe there is much to be learned from the success and limitations of the ESRD program. Medicare entitlement has provided access to care for many patients previously denied treatment. Yet, a small percentage of patients are not entitled to Medicare and must be considered in any health care package that provides universal access.

More importantly, as a program largely dependent on government reimbursement, the effects of price controls on quality of care and patient mortality must be evaluated.

ANNA appreciates the opportunity to provide this written testimony to the committee and is available if further information is needed.

Thank you.

National Association of Long Term Hospitals

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April 1, 1993

EXPRESS MAIL

Janice Mays, Esq.
Chief Counsel & Staff Director
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1102 Longworth House Office Building
Washington, D.C. 20515

Dear Ms. Mays:

These comments are submitted on behalf of the National Association of Long-Term Hospitals ("NALTH") for consideration by the Subcommittee on Health and for inclusion in the printed record of the hearing on budget issues relating to payment under Part A of the Medicare program. As long-term hospitals, NALTH members are exempt from the Medicare Prospective Payment System ("PPS"). Long-term care hospitals provide care for a catastrophically disabled and ill patient population that characteristically requires long lengths of stay at a hospital level of care. As documented in the ProPAC Interim Report on Payment Reform of PPS-Excluded Facilities, Congressional Report C-92-05 (October, 1992) (hereinafter "ProPAC Report"), 86% of long-term hospital patients in 1990 had multiple diagnoses reported in their medical record. Id. at 39. Thirty-nine percent (39%) had five diagnoses noted. Id. There is no dispute that long-term care hospitals care for patients who are very sick with multiple conditions Id. at 39.

A majority of patients cared for at long-term care hospitals are eligible for Medicare program coverage. Of these patients a significant number exhaust Medicare program benefits while receiving care and services in the long-term care hospital. Furthermore, many long-term care hospital patients are dual eligible, that is, they simultaneously receive benefits under both the Medicare and Medicaid programs. In other words, long-term care hospitals treat a significant number of poor and elderly patients.

Janice Mays, Esq.
 April 1, 1993
 Page 2

The ProPAC report indicates that of the five types of PPS-exempt hospitals, long-term care hospitals financially fare particularly poorly under the Medicare Program. The most recent information shows that in 1989 almost three quarters of long-term care hospitals (72%) had costs that exceeded their target amounts. Id. at 41. This was a significant increase from 1985, when only 44% of long-term hospitals had costs that exceeded their target amount.

In response to the reimbursement difficulties experienced by long-term care hospitals, Congress has updated the TEFRA target rate to the full market basket projected increase. However, in two years in the mid 1980's, a minimal update was used instead of the market basket inflation, resulting in the long-term care hospitals receiving almost no TEFRA rate increase. Therefore, long-term care hospitals have a critical interest in the Administration's proposals.

Long term care hospital concerns include proposals in the following areas:

(1) Rebasing

Long term care hospitals with early base years consistently are unable to meet their costs. In its October, 1992 report, ProPAC stated that the use of an early base year upon which to determine payments to long-term care hospitals may be inappropriate. This is true for possibly two reasons. First, long-term hospitals typically receive a substantial majority of their revenue from the Medicare and Medicaid programs. The below-inflation updates of these programs has resulted in reimbursement that is below cost. Second, most long-term hospital patients are dual eligible for Medicare and Medicaid, leaving the hospitals unable to attract significant private-pay reimbursement that can help subsidize the losses generated by the governmental programs.

To alleviate the adverse impact of these factors, NALTH supports a limited rebasing proposal in which a long-term care hospital can elect 1991 costs as the base for its target limit if it is eligible to receive a disproportionate share adjustment (as outlined below) and the hospital has exceeded its Medicare target rate, before adjustments, for at least two consecutive years.

(2) Disproportionate Share Adjustment

The purpose of providing a disproportionate share adjustment to PPS hospitals is to recognize the unquantifiable, increased costs of caring for patients who have low incomes. As discussed above, long-term care hospitals provide services to a significant

Janice Mays, Esq.
 April 1, 1993
 Page 3

number of seriously ill, poor patients. Despite that fact, however, long-term care hospitals are not allowed a Medicare disproportionate share adjustment. NALTH supports a requirement that a disproportionate share adjustment be provided for a long-term care hospital for which Medicare, Medicaid, free care or bad debt represents 30% or more of the hospital's gross charges.

(3) Hospital Update - Market Basket Rate of Increase

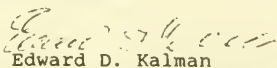
NALTH supports the setting of hospital updates at a minimum at the market basket rate of increase, particularly with regard to long-term care hospitals which through TEFRA already have been provided an incentive to increase efficiency in operations. Additionally, the average annual cost for Medicare cost per discharge at long-term care hospitals exceeds the market basket update. PROPAC report, 40-41. PROPAC suggested that several factors such as significant changes in case mix and the use of new technologies may have contributed to the cost increase. Id. at 42. These additional cost factors should be reflected in annual rate of increase adjustments.

Conclusion

Long term care hospitals provide services that are vital to the patient populations which they serve. NALTH members are owned by religious organizations, private charitable organizations and units of government which have concerns related to the programs and services required to properly treat their patients and which are unavailable in a non-hospital setting. We appreciate your consideration of our comments and have enclosed a Fact Sheet describing our concerns. In the future, NALTH would like to offer oral testimony before the Subcommittee on Health regarding issues of concern to providers of long-term hospital care. Please consider this letter a request to be included as an invited witness at future subcommittee hearings.

Thank you for your consideration.

Sincerely,



Edward D. Kalman
 General Counsel
 National Association of
 Long-Term Hospitals, Inc.

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National Association of Long Term Hospitals

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FACT SHEET NATIONAL ASSOCIATION OF LONG TERM HOSPITALS AGENDA

Background: Long-term hospitals are one of five classes of hospitals that are exempt from the Prospective Payment System used for acute hospitals. Long-term hospitals have the following characteristics and issues:

- . they serve a catastrophically disabled and ill population who have recurrent, unpredictable needs for medical management, technology, programs and other services which, as a practical matter, are not available in a non-hospital setting;

- . their patients have a long length-of-stay and present with multiple diagnoses, factors which preclude DRG reimbursement;

- . they are dependent on the Medicare and Medicaid programs for approximately 50 - 100% of patient care revenues;

- . they lack disproportionate share adjustment relief because, unlike most hospitals, no provision is made for a disproportionate share adjustment for long-term hospitals that have high proportions of Medicare and Medicaid patients.

For "old" hospitals:

- . Medicare reimbursement is based on costs as old as 1982

- . In October, 1992, PROPAC issued a report to Congress noting that payments to long-term hospitals are inadequate and long-term hospitals fare less well than other classes of PPS exempt hospitals and PPS hospitals

- . HCFA has not afforded payment adjustment opportunities to allow "old" hospitals to meet their cost. "New" hospitals are paid actual costs and may receive incentive payments

National Association of Long Term Hospitals
Page 2

NALTH PRIORITY PROPOSALS

I. Require the Secretary of HHS, effective for Medicare cost reporting periods commencing in 1991, to assign a new base year for:

- . any long-term hospital which meets a disproportionate share test of 25% of total revenues derived from Medicare, Medicaid and free care;

- . has experienced two years of Medicare target rate payment, before adjustments, that are less than Medicare allowable cost.

1991 would be assigned as the initial base year and additional base year assignments would be available if a long-term hospital continued to meet the above two criteria

II. Provide long-term hospitals with the same disproportionate share adjustment which is currently available to PPS hospitals by using the following formula:

$$(p. 15\%) (.65) + 2.5 \text{ where } p = \frac{\text{Medicare SSI patient days}}{\text{Medicare patient days}} + \frac{\text{Medicaid patient days}}{\text{Total patient days}}$$

- . Require that states also implement this same formula for PPS exempt long-term hospitals under the Medicaid program and require that states actually make resulting disproportionate share payments in addition to amounts presently required by Section 1902a(13)(A) of the Social Security Act.

III. Legislatively overrule the Secretary's regulations limiting relief required by 1990 OBRA for wage adjustments due to atypical increases in labor costs. The Secretary has limited relief with a threshold eligibility requirement that a PPS exempt hospital's wages must exceed the area wage index by 108%, and has limited relief to 105% of the increase in the national wage index. These criteria result in the exclusion of practically all hospitals from relief under the law and is inconsistent with Congressional intention.

nalth\fs.doc\jan

NATIONAL KIDNEY PATIENTS ASSOCIATION

804 SECOND STREET PIKE, SOUTHAMPTON, PA 18966 215-953-9200

March 15, 1993

EPO

We appreciate this opportunity to bring forth our views of EPO and its cost to the government. Our Association has been very vocal about the ESRD program for the past ten years. As administered, patients receive a decreasing quality of care as the government is being asked to contribute more and more funds.

There are two major problems with this program. First, the reuse of medical disposables, those devices labeled for one time use by the manufacturer, and secondly, the cost, distribution and use of EPO. Our remarks will be confined to the EPO issue for the purposes of this presentation, but wish to be considered at some future time to discuss the ESRD program in more detail.

BACKGROUND

AMGEN is the sole manufacturer of EPO, and enjoys the luxury of being a monopoly. Current reimbursement rates were established in order to provide a very small, perhaps \$.50 profit for the providers, who control its distribution and use. The average patient receives EPO three times a week. As we understand the situation, AMGEN received approval for EPO under the Orphan Drug Act. Their initial application represented that EPO would be required by less than 17% of the dialysis patient community. Today, they enjoy a 92% participation. Why such a tremendous increase in usage over the anticipated? AMGEN developed a great marketing plan, by which they could feed off of the greed of the provider, and increase sales.

FACT: The vials of EPO come in 2,000, 3,000, 4,000- and 10,000. units.

FACT: The product is labeled for single use only, "Do Not Re-Enter The Vial", because there is no preservative.

FACT: AMGEN overfills the vials by 25%

FACT: AMGEN informs their clients that they may use the excess, violate the manufacturers labeling requirement and multi dose the EPO.

FACT: AMGEN salespeople solicit the providers, and deliver "dead space" syringes, in order to help them achieve complete use of all material in the vial.

FACT: AMGEN salespeople show the providers how they can bill the government for the excess in the vial.

FACT: AMGEN grants substantial kickbacks for volume users. Between 9-11 %.

A prudent person might ask why a monopoly would do all of the above. The answer is obvious. This marketing ploy has increased the volume so substantially that AMGEN can afford to give away 25% of their product for free, and reward the users based upon volume.

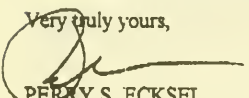
In order to qualify for EPO, a patient must have a hematocrit below 36. A provider is thereby granted an incentive to cut back on the patient's iron supplement. This action will guarantee the hematocrit levels will remain below 36 indefinitely. Based upon conversations with industry professionals, we can conclude that this practice is rampant. It has resulted in the skyrocketing success of AMGEN, and the abnormal, extremely high usage of EPO, and of course, the windfall profits. There is a Conspiracy to defraud afoot, and the two largest beneficiaries are AMGEN and a subsidiary of WR Grace and Co, National Medical Care, but the actions they demonstrate are industry wide, and one would be hard pressed to find a firm that doesn't participate in the AMGEN program.

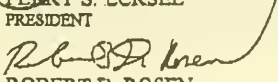
We therefore, believe that cutting the reimbursement rate by \$1.00 would not even begin to right this situation. Nor would the reduction save the government any money. The action would actually encourage fraud. The reimbursement rate would be set at a level below the cost to the provider, and the only method available to them for a profit would be through illegal means. There is a simple solution. First we suggest that proper steps be taken to eliminate the kickbacks. If indeed, the actions are illegal, then reimbursement of the overage and kickbacks should be sought. The label on the product should be enforced. This could eliminate the 25% overfill. Then, EPO should be made available through pharmacies as it is in Germany. A nationally negotiated price could be developed. This action would eliminate the windfall profits by the providers, and reduce the profit incentive for excess usage of EPO.

We are a patient advocacy association, and would be remis in our responsibility if we didn't point out that it's not only the money. The product that is being used in a manner inconsistent with its labeling has been adulterated. In an industry where patient infection is commonplace, no one would be able to distinguish the cause, but we believe that significant percentages infections can be attributed to the introduction of bacteria associated with this misuse.

Thank you for your courtesies and cooperation. We really appreciate your interest.

Very truly yours,


 PERRY S. ECKSEL
 PRESIDENT


 ROBERT D. ROSEN
 CHAIRMAN

nmc National Medical Care, Inc.

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NATIONAL MEDICAL CARE, INC.
ESRD PROGRAM ISSUES BEFORE THE CONGRESS IN 1993

The purpose of this paper is to convey the position of National Medical Care, Inc. (NMC) concerning End Stage Renal Disease (ESRD) program issues before the Congress in 1993. NMC is the largest and most experienced dialysis provider in the nation and supervises the care of approximately 30,000 dialysis patients, most of them Medicare beneficiaries, in a network of over 400 Medicare-certified outpatient facilities in 37 states.

INTRODUCTION.

From its beginning in 1972, Medicare's ESRD program has been subject to a unique set of reimbursement and policy forces which have produced both unparalleled policy successes and, increasingly within the last decade, serious policy shortcomings. The successes (rapid development of a system of care to meet the needs of all Americans; successful control of unit costs in an era of rampant health cost inflation) and the failures (excessive reduction in real resources available for patient care; uneven and by some measures inadequate quality of care) flow from the same source: close central control of dialysis services by the government, through the initial decision to make ESRD a Medicare entitlement and subsequent year-to-year micro-management of reimbursement rates for dialysis services.

The 1972 decision to provide Medicare coverage for all ESRD patients provided the financial engine to drive development of our present system of care, but also fostered an excessive exposure of dialysis providers and patients to the year-to-year vagaries of the Federal budget process. Dialysis providers are more dependent upon Medicare and have fewer privately insured patients than any other class of providers. They lack the buffer against public budget reductions, and the opportunities for cost-shifting, which accompany a more normal payer mix. Because there is no private payer safety valve for dialysis providers, real reductions in the Medicare payment rate for dialysis have over the years resulted in significant reduction in total resources available for patient care. Mortality rates have gone up and are said to be substantially worse than those of many other countries, and there is no strategy within the Government to deal with dialysis quality assurance and improvement.

As we contemplate structural reform of our overall health care system, we have today the opportunity to solidify and build on past successes, ameliorate these increasingly troublesome problems, and hasten the integration of dialysis and other ESRD care into the normal operations of an effective and cost-efficient national health care system for all. The positions detailed below, taken together, serve this unified goal.

SPECIFIC RECOMMENDATIONS.

1. The dialysis composite rate should be increased for FY 1994 by at least the 2.5% recommended by PropAC.

Adjusted for inflation (CPI-All Urban), the 1983 composite rate of \$126 has by 1993 been reduced in worth to barely \$88. Stated differently, the resources represented by the dialysis payment rate have declined by more than 30% on account of inflation over 10 years. If we compare today's rate to the \$138 payment level of 1973, it's inflation-adjusted worth is less than \$35, and the resources represented by the rate have declined by fully 75%. No other class of health care providers has absorbed real reductions in resources on this scale.

Given this payment rate history, it can be no surprise that quality of care has been affected (although HCFA has consistently denied, against all evidence, that dialysis facilities are affected by inflation or that there are unmistakable signs of quality decay). Congress has been responsive to quality problems and in OBRA-86, in response to warnings from industry, first expressed its concern about the effects of reimbursement policy on quality of care for dialysis patients. That question was explored by a research team at the Urban Institute, and later by a special study panel at the Institute of Medicine, which in 1991 concluded that further real reimbursement reductions would pose a serious threat to patients, and that the dialysis composite rate should be adjusted to account for inflation. In OBRA-91 Congress commissioned the Prospective Payment Assessment Commission (PropAC) to recommend an annual update factor for the dialysis composite rate and to review dialysis payment methodology. In March 1993 PropAC reported to Congress recommending a 2.5% update factor for dialysis in FY 1994.

Seven years have elapsed from Congress' first statement on dialysis quality to its consideration of a clear policy recommendation for an inflation update from a neutral and expert body. Inflation in provider costs has continued throughout that period. It is, finally, time to give dialysis providers and their patients some necessary relief from the ravages of inflation, and to institutionalize for dialysis the same annual adjustment process that governs other Medicare payment rates.

It is also important to recognize that dialysis providers receive less today than at the inception of the composite rate system in 1983, or at the initiation of the ESRD program in 1973. They are, in this particular, absolutely unique within the Medicare program. Consequently, every effort should be made to provide the ProPAC recommended update this year even if some other programs (which have enjoyed annual updates throughout this period) do not receive updates on account of budgetary pressures.

2. The Medicare payment rate for erythropoietin (EPO) should be maintained at the present \$11/1,000 units, and an alternative payment method to incent more efficient use of the drug and/or to reduce total Program costs should be considered.

EPO, manufactured and distributed to the dialysis community under orphan drug protection by Amgen Inc., has freed dialysis patients of dependency on blood transfusions, allowed pharmaceutical management of the anemia of renal disease, and substantially improved the well-being of many patients. At present, about 90% of all chronic dialysis patients receive EPO.

While undeniably beneficial, EPO is also expensive. Medicare presently pays for EPO at \$11/1,000 units, which represents the nominal manufacturer's price of \$10/1,000 units plus a small allowance for additional costs borne by the dialysis facility. Patients receive doses with each dialysis treatment (i.e. three times per week); the average dose is in excess of 3,500 units. The Medicare program is thus rightly concerned about controlling EPO costs, and many in the Congress and in DHHS believe that Amgen is realizing excessive profits from the drug.

A proposal to reduce the Medicare rate for EPO to \$10/1,000 units is under consideration. Some members believe that dialysis facilities will be able to extract price reductions from the manufacturer if faced with a reimbursement rate inadequate to cover their costs under present pricing. Congress further believes that some providers receive discounts from the manufacturer's price, thus allowing room for a rate reduction.

The proposed reduction in payment to facilities will reduce patient access to EPO and have a detrimental effect on overall quality of dialysis care. For one thing, supporters of the reduction understate the real non-labor costs of EPO to facilities, and fail to take account of the uncollectible portion of the patients' copayment. Suppose for example that a patient has no coinsurance. In such a case, total payment for a 3,000 unit dose is \$26.40 rather than \$33.00. Without considering the costs of storing and administering the EPO, the facility would lose \$3.60 for each dose purchased at the \$10/1,000 unit market price. With a 5% discount from Amgen this loss would be \$2.10 and with an 8% discount it would be \$1.20. At an EPO discount of

about 12% the provider would cover its acquisition cost, and its loss would be limited to the costs associated with EPO storage and administration. Reduce the Medicare rate to \$10/1,000 units and the loss becomes \$6.00 with no discount, \$4.50 at 5% and \$3.60 at 8%. Product cost "break-even" in the absence of coinsurance occurs at a 20% discount.

Numerous facilities will obviously be confronted with the choice of absorbing a loss or not giving the drug. Due to the patient-specific and dose-dependent way in which Medicare pays for EPO, it is very easy and perhaps unavoidable to make the loss calculation on a patient-by-patient basis, and to allow that calculation to influence prescribing behavior. Facilities may also cover any EPO losses by diverting resources from other sources, in effect subsidizing EPO. As dialysis quality has already been harmed by inadequate reimbursement, this can only result in further quality erosion. Any proposal which reduces the total financial resources available to dialysis facilities for patient care is extremely dangerous in light of IOM and PropAC findings.

Congress' goal of controlling total EPO costs may best be realized by folding an allowance for EPO into the dialysis composite rate on a cost-neutral basis, and allowing facilities to use their market power to secure the best possible price. Medicare could then adjust the EPO allowance on the basis of audits of real costs as part of the annual reimbursement review which PropAC will perform. In this way, facilities would be incented to secure unit price reductions and total cost savings, and to deal with the clinical needs of their patients within a unified total package, rather than in segments defined by reimbursement arrangements. Integrating payment with the composite rate makes EPO simply one among many variables in the total treatment cost equation, and eliminates incentives based on the specific patient's payment resources. Quality of care would be improved, and Medicare would share in facility cost savings without compromising patient access or quality of care.

3. **The ESRD Medicare Secondary Payer period should be extended from the present 18 months to at least 24 months.**

For ESRD beneficiaries, Medicare is secondary to employment-based insurance for the first 18 months of Program eligibility. This Medicare secondary payer period was lengthened from 12 months in 1990. For other Medicare beneficiaries, Medicare's secondary status lasts as long as the employment-based insurance is present. Medicare in effect subsidizes private insurers by limiting their exposure to the bulk of costs for covered ESRD patients to the 18 month Medicare secondary period.

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5

GAO estimates that the 1990 six month extension to the secondary payer period for ESRD saved Medicare \$56 million per year; NMC's experience would yield a higher savings estimate. By any account, a further 6 month extension (to 24 months) would more than pay for implementation of the ProPAC rate recommendation.

For providers, a secondary payer extension beyond 18 months would lessen reliance on Medicare as a payer. Dialysis facilities receive a higher percentage of their total revenues from Medicare than do other providers; they are more susceptible to Federal budget emergencies; they are effectively isolated from a variety of innovative insurance and payment reforms emanating from the private insurance industry. They are consequently disadvantaged by their excessive reliance on Medicare as a payer when confronting options for structural health care reform now under serious discussion. Providers might also receive an immediate benefit in the form of higher private insurer payment rates, but that would be extremely short-lived as insurers turned their attention to dialysis - which many have ignored in the past because of Medicare's "subsidy" to them.

When the ESRD secondary payer period was extended in 1990, Congress asked the General Accounting Office (GAO) to study whether the change had any adverse effect on patient employment. An interim GAO report in December 1992 found no evidence that extending the ESRD Medicare Secondary Payer Period increased discrimination against ESRD patients or their spouses. ESRD patients are already protected from employment discrimination by the Americans with Disabilities Act and by the express requirement (enforced through a surtax) that group health plans provide dialysis coverage. The general insurance market reforms being considered this year provide further protections by mitigating or eliminating insurance and employment access problems associated with preexisting conditions, portability, and experience rating. There is simply no good reason for Medicare to continue its subsidy of the private insurance sector for ESRD beneficiaries.

CONCLUSION.

These three policy positions, taken together, would:

1. Provide a modest but much needed increase in the resources available for dialysis patient care, and thereby allow providers to further address quality of care shortcomings;
2. Protect patient access to EPO while implementing incentives for more efficient use of that drug which ought over time to produce real Program savings;

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6

3. Lessen the unhealthy and increasingly unnecessary reliance of dialysis providers on Medicare as virtually the sole payer for services, and achieve a more reasonable balance between public and private sectors in responsibility for dialysis, commensurate with that for other health services; and
4. Yield immediate savings which could be used to finance the inflation adjustment to the composite rate.

They provide what we believe to be a responsible and necessary response to the specific problems confronting ESRD patients and providers, as well as the Medicare program, as we confront the Federal budgetary deficit and embark upon structural reform of the American health care system.

CONTACT: Edward E. Berger Ph.D.
Vice President for Government Relations

**TESTIMONY OF
THE NEW YORK STATE COUNCIL ON GRADUATE MEDICAL EDUCATION
Lambert N. King, M.D., Ph.D
Chairman**

to the
**Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives**

March 18, 1993

The New York State Council on Graduate Medical Education is a governor-appointed body established in 1987 to advise to state policymakers on the composition, content, supply, and distribution of graduate medical education programs in New York State. Since its inception, the Council has carefully considered and developed recommendations on issues such as the balance of primary care and specialty training, the development of graduate medical education consortia, and the underrepresentation of minorities in GME programs. It is with this experience in mind that the Council has evaluated President Clinton's proposed changes in graduate medical education which are included in his economic proposal, *A Vision of Change for America*.

The President's economic proposal calls for Medicare hospital reimbursements for direct medical education (DME) costs to be based solely on a national average resident salary which would be weighted at 240% for primary care residents, 140% for non-primary care residents in their initial training period, and 100% for non-primary care residents beyond their initial training period. While the Council lauds the President's effort to support primary care training, we recognize some significant problems with this proposal:

- Graduate medical education is an integral component of the health care system which, we believe, deserves a comprehensive debate within the context of health care reform. The changes proposed by President Clinton represent a major shift in federal graduate medical education policy in the form of deficit reduction measures. The changes fail to address the major reforms that are needed in graduate medical education.
- The proposed DME spending reductions are achieved by eliminating support for supervisory physicians, which are at the heart of all graduate medical education programs. These reductions will jeopardize patient safety, quality of care, and the actual teaching of residents.
- These cuts have a disproportionate impact on New York teaching hospitals. Of the \$350 million in proposed 1994 savings, nearly \$200 million will be borne by New York hospitals alone. The proposed policy discriminates against New York hospitals, and other urban teaching hospitals, which, under the current health care system, meet the health care needs of their large indigent populations through the vital services of residents and their supervising physicians.

During graduate medical education (GME), interns and residents are given graduated responsibility for the care of patients based on their individual capabilities. GME requires the supervision of residents by experienced physicians. Because many of New York's indigent patients do not have personal physicians, residents and their supervising physicians fulfill this role. The services of supervising physicians are compensated through DME payments rather than through a separate billing to the Medicare program. In fact, a recent study found that New York has one of the nation's lowest levels of Medicare inpatient billing for physician services. Medicare has recognized supervisory physician costs as legitimate expenses and has included them in DME reimbursements. By drastically cutting out these payments, this proposal penalizes only those regions and hospitals which, because of their large indigent populations, have had to rely on a different model of care.

The GME portions of the President's proposal, which are intended to reduce federal spending, have profound implications for the financing and organization of physician training in the United States. It is, in effect, a major change in graduate medical education policy which has not been considered and debated in the context of health care reform. These massive reductions to GME programs will, in fact, severely limit the opportunity for rational primary care-oriented reform of GME programs in New York State and in other states and cities in which academic medical centers are concentrated.

While the New York State Council on Graduate Medical Education opposes the proposed DME cuts in the absence of other health care reforms, we strongly believe that certain reforms need to take place in graduate medical education. In its five years of work on this issue, the Council has recognized that reform of GME cannot occur in isolation; GME is an integral part of our health care system that, indeed, reflects a series of choices we have made about the delivery of health care.

The Council's deliberations and recommendations have focused on several specific GME issues which I encourage this Subcommittee to consider in its deliberations on health care reform. I would like to take the opportunity that this hearing presents to raise several of these issues.

Specialty versus Primary Care Mix

The President's proposal to weight DME reimbursements in favor of primary care is an indication of the Administration's concern about the growing shortage of primary care physicians. The Council shares this concern about the growing imbalance in the proportion of residents training for careers in the medical and surgical subspecialties to those preparing for careers in the generalist, or primary care, specialties. In New York State, approximately 32 percent of the practicing physicians are generalists. Less than 30 percent of the residents training in New York's graduate medical education programs are preparing for careers as generalists and an even lower percentage of students in New York medical schools intend to pursue generalists careers. These figures are similar on the national level.

To address this issue, the Council felt that incentives should be provided to hospitals to encourage training of primary care physicians and discourage the training of additional medical and surgical subspecialists. The Council recommended that non-Medicare hospital reimbursements for indirect medical education (IME) be weighted to favor the training of primary care physicians and that increased revenues received as a result of the weighting system be allocated to primary care residency programs. This weighting system was adopted in New York State and put into practice in July, 1992.

While we are encouraged by the initial changes resulting from this new policy, the Council feels it would be premature to comment on its impact on the ratio of generalist to specialist training positions. We also feel that it would be premature to replicate a resident weighting system on a national basis. The President's proposal would not only weight DME payments to hospital based on the specialty mix of their residents, it would greatly reduce payments for all DME expenses beyond resident stipends. Such reductions in support for graduate medical education programs would jeopardize the financial viability of primary care residency programs as much or more than medical and surgical specialty programs despite their increased weight. However, extending New York's experiment in IME weighting to include Medicare may be an ideal way to test the weighting concept.

To further buttress primary care training, New York will soon establish a statewide loan repayment program for primary care residents. All primary care residents who meet established criteria will be eligible for loan repayment awards during their residency training, with larger awards going to those who train in medically underserved areas.

Obviously, reforms will need to occur in both the practice setting and in medical school in order for primary care to regain significant ground as a specialty of choice among the nation's physicians. Recent estimates have indicated that even if half of each medical school class

pursued primary care beginning next year, we would not achieve a 50 percent ratio of generalist to specialist physicians until at least the year 2030. Intensified efforts must be made at each level of the medical education continuum, including graduate medical education, in order to achieve a balanced physician supply in a reasonable timeframe.

Limit Growth in Resident Supply

New York, perhaps more than most states, has recognized the need to limit the growth in the number of residents training in its residency programs. New York has the largest graduate medical education enterprise in the nation, with 14,000 residents or roughly 16 percent of all residents currently in training in the U.S. New York's high numbers are a result of a combination of factors, one of which is simply the historical concentration of medical schools and teaching hospitals in New York.

Other factors include New York's regulated all-payor hospital reimbursement system, which severely restricts increases in hospital reimbursement rates and cost-shifting to support the costs of GME. New York City also houses the largest municipal hospital system in the nation which guarantees hospital care to anyone who needs it. Such an enterprise attracts very few well-insured patients with established physician relationships. Consequently, residents and their supervising physicians become the principal caregivers in such facilities. In addition, New York is the only state to have mandated limits on resident work hours, leading to some increases in the number of residents hired.

Responding to the excess supply of residents by mandating a reduction in the number of hospital-based residency positions does not address the fundamental question of who will provide care in place of residents and how to pay for that care. As the demand for ambulatory-based training of physicians increases, these questions will become even more compelling. The Council looks toward the development of graduate medical education consortia as an appropriate vehicle for addressing this issue.

Graduate Medical Education Consortia

A GME consortium, as defined by the Council, is a medical school, its affiliated hospitals, and other affiliated teaching sites which share responsibility for graduate medical education programs. We believe that GME consortia in which regional planning for graduate medical education is undertaken can enhance the educational quality of residency programs, reduce duplicative aspects of separately administered graduate medical education programs, and foster the ability to meet consortium and societal goals, such as increased levels of primary care training, rather than institutional or departmental needs alone.

Two active consortia have been established in New York State, one centered in Buffalo and one in the New York metropolitan area. Both consortia are working toward specific GME goals. The Graduate Medical and Dental Education Consortium of Buffalo, for example, has set a cap on the number of residency positions that will be offered at consortium-affiliated institutions and has begun efforts to achieve a 50 percent ratio of residents training in primary care specialties. The New York Medical College Medical Education Consortium has developed a special primary care track which combines some aspects of undergraduate and graduate medical education. Students accepted into this track complete both medical and graduate medical education in six years, rather than the traditional seven years.

These types of activities can be successful only if a close, collaborative relationship is established between medical schools and their affiliated teaching sites. The New York State Council on GME is aggressively pursuing the development of additional consortia in New York State and has strongly advocated that funds be made available to support these efforts.

Funding for both consortia development and the loan repayment programs in New York will be made available out of a state pool of non-Medicare indirect medical education monies to which

teaching hospitals will contribute. The pool will be established by collecting a small percentage of the current \$925 million in non-Medicare IME now being paid to New York teaching hospitals. These funds will be targeted to pressing graduate medical education needs, such as loan repayment for primary care residents, development of GME consortia, and minority participation projects.

Strategies for Reform

To date, the New York State Council on Graduate Medical Education has advocated the following policies for GME reform in New York State:

- Weighting non-Medicare indirect medical education payments to favor primary care;
- Establishing a loan repayment program that guarantees awards to primary care residents during their training;
- Developing graduate medical education consortia and supporting on-going consortia efforts to achieve GME reforms; and
- Pooling portions of non-Medicare indirect medical education payments to fund targeted GME reform measures.

We are continuing to study additional strategies. At a recent meeting of the New York State Council on GME, representatives of the Physician Payment Review Commission (PPRC) discussed their current recommendations for graduate medical education reform. In my view, these recommendations are the most meaningful and substantive yet proposed on a national basis. The New York State Council on GME, which is carefully considering these recommendations, is supportive of many the objectives of the PPRC proposal. For example, the Council strongly advocates the principle of spreading the costs of GME across all payors of health care services. This principle is espoused in the PPRC's proposal to establish a national pool for funding GME to which all payors would contribute.

I believe there would be substantial support within New York State to work with the Federal government to meet the objectives described in the PPRC report. As you deliberate health care reform, I encourage this Subcommittee to consider the GME reform strategies presented by the New York State Council on GME and the PPRC. I also encourage you to consider working cooperatively with New York State on these reform measures by allowing flexibility in the use of Medicare GME reimbursements in order to implement change. Thank you for the opportunity to present our thoughts on this very important issue.



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STATEMENT OF THE
RENAL PHYSICIANS ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
FOR THE RECORD OF THE HEARING
MARCH 18, 1993

RE: BUDGET ISSUES AS THEY RELATE TO MEDICARE PART A
AND END-STAGE RENAL DISEASE (ESRD) SERVICES

The Renal Physicians Association (RPA) is taking this opportunity to provide a statement to the House Ways and Means Subcommittee on Health for the record of the March 18, 1993 hearing on budget considerations for Medicare Part A and End-Stage Renal Disease services.

RPA is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

Our comments will focus on the President's budget proposals and related matters which affect End-Stage Renal Disease (ESRD) services.

Payment Reduction for Erythropoietin (EPO)

Erythropoietin or EPO is a pharmaceutical used by patients suffering from kidney failure to counter anemia by increasing the body's production of red blood cells. EPO has allowed many dialysis patients to return to work and/or to lead more normal and fuller lives. Nephrologists, dialysis facilities, hospitals, and patients all need to purchase this drug because of medical need in the various settings in which this drug is administered.

Under the President's proposal as well as HR 21, Medicare payments for EPO would be reduced from \$11 to \$10 per 1,000 units. While we understand that this payment reduction is directed at the drug's manufacturer, RPA is concerned that this reduction not be passed on to patients and providers in the form of higher prices. Individual nephrologists and dialysis facilities are not in a position to negotiate rates with the manufacturer or suppliers, let alone patients. We must pay whatever the drug company or supplier charges.

Medicare expects nephrologists and dialysis facilities to pay for EPO from capitated rates which are already in need of desperate updates (see related discussion below on the need to increase the composite rate). These are the Monthly Capitated Payment (MCP) rate paid to nephrologists for treating dialysis patients in the outpatient setting (the subject of another paper), and the Composite Rate paid to dialysis facilities for outpatient maintenance dialysis treatments and related services (see below). While nephrologists and dialysis facilities pay for EPO to administer to patients, some patients do also purchase the drug fully out of pocket for home administration.

The issue of drug pricing and its impact on access is a complicated one. The RPA cannot claim that this proposed reduction would impede access to EPO, but we would urge this Committee at the very least to direct HCFA to closely monitor and annually report on access to EPO if this reduction in the EPO rate is enacted.

Extending and Altering the Medicare Secondary Payor Provision for ESRD Beneficiaries

The President's proposal calls for permanently extending the Medicare Secondary Payer (MSP) provision for ESRD patients from 12 to 18 months. This extension would otherwise expire in

January 1996. Last year's Medicare package as included in HR 11 would have extended this provision to 24 months through 1995 for ESRD patients. During these initial periods, employer provided group health plans are expected to serve as primary payer for ESRD related medical expenses before Medicare would kick in.

The President's proposal would also make uniform all the other MSP provisions which affect not only ESRD beneficiaries, but also the aged and disabled. The plan would make all employer thresholds consistent with the aged provision which is 20 or more employees. That is, all employers with 20 or more employees with a group health insurance plan would be required to act as primary payer for its aged, disabled, and Medicare ESRD entitled employees for specified amounts of time. This requires a reduction in the disability provision from 100 to 20 employees and the creation of a 20 or more employee threshold for ESRD beneficiaries. Currently, all employer health plans, regardless of the number of employees, are required to serve as primary payers for beneficiaries who have become entitled to Medicare solely because of ESRD 'as opposed to becoming entitled because of age or disability).

Lastly, the President would also eliminate the exemption from the MSP provision for individuals with ESRD who are also aged or disabled. Payments for these individuals would be treated the same as with payment for beneficiaries entitled to Medicare solely because of ESRD.

A recent interim General Accounting Office (GAO) report¹ which studied the effects of the OBRA '90 ESRD MSP extension from 12 to 18 months, showed that the extension appeared to have negatively affected some beneficiaries' or their spouses' access to and retention of employment or employer health insurance. Although the numbers are relatively small this is cause for concern especially since the sample size was limited. A broader study should be conducted before Congress decides to make this extension permanent. In addition, the GAO's study of the effects of this provision is not completed. The GAO has yet to report on beneficiary out of pocket expenses and other issues, expected to be completed in January 1995.

Since we do not know yet what President Clinton's health care reform proposal will look like, it is difficult to speculate on how this provision will affect ESRD patients under a new health care system. ESRD patient and spousal access to health insurance (and job discrimination) is an issue that should be analyzed within the context of the President's health reform plan.

Increasing the Composite Rate Paid to Dialysis Facilities

The Prospective Payment Assessment Commission (ProPAC) has recommended to Congress that the composite rate for dialysis facilities be updated by 2.5 percent for FY 1994. The RPA fully supports this long overdue update and urges Congress to enact this recommendation. As you may know, the composite rate paid to renal dialysis facilities for outpatient maintenance dialysis treatments and related services under Medicare has essentially been either frozen or reduced since the rate was established in 1973 with the exception of a \$1 increase per dialysis treatment in 1991. Even with this \$1 increase in 1991, the composite rate has dropped over 60 percent in real dollars because of explicit freezes and rate reductions and the unadjusted effects of inflation² since 1974.

It is true that there were some productivity increases in the 70s and part of the 80s which allowed many dialysis facilities to operate successfully with the established rate, but reports about jeopardizing quality of care under these real dollar decreasing rates, especially from such notable sources as the Institute of Medicine³, is cause for alarm.

¹ Medicare: Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans, United States General Accounting Office Report to Congressional Committees (December 1992).

² See Kidney Failure and the Federal Government, Institute of Medicine (1991); and Committee on Ways and Means, U.S. House of Representatives, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means (aka: the Green Book), (1992 Edition).

³ ibid.

While there is not as much available and reliable data upon which to make a decision in this area as some would like, it is clear that some update is called for. A 2.5 percent increase in the composite rate as recommended by the ProPAC would at least provide in part for inflation and the extra costs associated with EPO, and the new regulatory burdens of CLIA, OSHA and ADA. With these extra costs and the fact that the rate has not been evaluated or updated in 20 years (with the exception of the \$1 dollar per treatment increase in 1991), a 2.5 percent increase is modest in any terms.

RPA's concerns about the quality of patient care is number one on our agenda. We are involved in practice guidelines research and development and are working with the Agency for Health Care Policy and Research (AHCPR) and the National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDK). Our efforts are also integrally connected with the U.S. Renal Disease Data System also known as the ESRD Patient Registry. A 2.5 percent update in the composite rate, as recommended by ProPAC, would certainly help renal dialysis facilities to maintain (and possibly improve) the quality of care provided to ESRD beneficiaries.

Health Care Reform and Consideration of Benefits for Inclusion In a Standard Health Benefit Package

As you are well aware, the President's Health Task Force chaired by Hillary Rodham Clinton is in the process of developing a standard benefit package for all Americans. Although the subject of a separate hearing by this subcommittee, we would be remiss without commenting on the standard benefit package within the context of any discussion about ESRD services. With health care reform closer now than ever, the RPA is very concerned that the standard (basic or comprehensive) benefit package offered in any health care reform proposal specifically include all medically necessary renal related services including dialysis and renal transplantation.

The Medicare End-Stage Renal Disease (ESRD) program covers almost 93 percent of ESRD patients or approximately 150,000 individuals. While this program should remain intact as part of health care reform⁴, there are a growing number of individuals who are not eligible for the Medicare ESRD benefit but who need ESRD services⁵. We believe it is therefore necessary to cover these individuals under the standard package. RPA would urge this committee to ensure that all Americans are covered for medically necessary renal related services including renal dialysis and transplantation either through the Medicare ESRD program or through a standard benefit package that all health plans or employers would have to provide.

Dasubwm 318

⁴ Although an assessment of the Medicare ESRD program within a new health care system should follow, the program could now serve as a model for health care reform. With prospective capitated payments for dialysis related physician services and treatments, the ESRD program is a model of cost effective managed care. In fact, according to HCFA's own data, per patient costs have decreased over time. This virtual single payer system (for a specific disease) has contained costs, expanded access to quality care and lengthened life expectancy.

⁵ Kidney Failure and the Federal Government, Institute of Medicine (1991).

**BUDGET ISSUES RELATING TO PAYMENT
UNDER PART B OF THE MEDICARE PRO-
GRAM FOR PHYSICIAN SERVICES, CLINICAL
LABORATORY TESTS, AND DURABLE MEDI-
CAL EQUIPMENT**

THURSDAY, MARCH 25, 1993

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, D.C.***

The subcommittee met, pursuant to notice, at 9:32 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[Press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 11, 1993

PRESS RELEASE #7
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON

BUDGET ISSUES RELATING TO PAYMENT UNDER
PART B OF THE MEDICARE PROGRAM FOR PHYSICIAN SERVICES,
CLINICAL LABORATORY TESTS AND DURABLE MEDICAL EQUIPMENT

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on budget issues relating to payments under Part B of the Medicare program for physician services, clinical laboratory services and durable medical equipment.

This hearing will be held on Thursday, March 25, 1993, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

On February 17, President Clinton announced his budget proposals for fiscal year 1994. The President's proposal includes a variety of recommendations which would affect payments to physicians, clinical laboratories and durable medical equipment suppliers under Part B of the Medicare program. The plan also includes a proposal to extend the current ownership and referral prohibitions to additional services beyond clinical laboratory services.

The Congressional Budget Office has estimated that these proposals would reduce payments for physician, laboratory, and durable medical equipment by \$13 billion over five years.

Testimony will be heard from the Physician Payment Review Commission. On March 31 of each year, the Commission submits its annual report to the Congress which includes recommendations on policies concerning physician payments under the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, April 8, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

- 1 All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages
- 2 Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee
- 3 Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted
- 4 A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing may be submitted in other forms.

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Chairman STARK. Good morning. If our guests would find seats, the subcommittee will begin its consideration of issues related to the fiscal 1994 budget. Last week, we focused on part A issues, and today we will consider issues relating to payments for physician services under part B.

According to CBO, physician payments under part B are projected to grow at an annual rate of 12.7 percent over the next 5 years. This growth creates unacceptable burdens on both the Federal budget and the household budgets of the elderly.

President Clinton's budget proposes extremely modest reductions in the part B program. Under his plan, total outlays for physician services in 1998 will drop only \$3 billion—from \$57 to \$54 billion. This reduces the effective annual rate of growth by only about 1.2 percent. In other words, it will drop from 12.7 to 11.5 percent.

Inflation and growth in the number of beneficiaries account for roughly a third of this amount, or about 4 percent a year. The remaining 8 percent of growth is due to persistently high and unacceptable growth in the volume and intensity of services provided.

The growth in part B is not due solely to physician services. Payments for lab tests are increasing at more than 20 percent each year; durable medical equipment is growing at nearly 14 percent each year.

The fact remains that physicians, through their clinical decisions, determine 80 percent of all health care spending. Effective cost containment must begin with the physicians.

Four years ago, this subcommittee made a small start when it initiated legislation creating the Medicare Volume Performance Standard system.

This system is based on a simple concept. We negotiate spending targets with physicians and set them prospectively. If spending is less than the target, physicians are rewarded with increases in their updates. If the reverse is true, the updates are reduced.

This system provides physicians with a modest incentive to begin controlling growth in health care services. Last January, physicians providing surgical services reaped the benefits of their restraint when the growth in spending for surgical care grew 0.4 percent less than the established target.

Next January, I think all physicians will see the benefits of this system. Two years ago, when implementing the RBRVS system, the Bush administration imposed a substantial reduction in the initial conversion factor due to what is known as a "behavioral offset." I believed this policy was wrong when it was proposed 2 years ago, and I fought to have it eliminated from the implementing regulations.

While we lost that battle, we may yet win the war.

Based on preliminary data, CBO has estimated that physician spending during 1992 was 6.3 percent below the targets. If these estimates are borne out, they mean that because of the existence of MVPS, the errors made 2 years ago can be corrected through increases in the baseline update for physician services.

I believe that the MVPS is an important example of how physicians and Government can work together to restrain growth in costs.

The MVPS provides a framework for negotiating reductions in the growth in spending;

It sets goals on a prospective basis, allowing physicians to organize to meet the targets; and

It provides predictability in spending for Medicare, and in revenues for physicians.

From our previous hearings on the implications of rising health care costs, it is clear that we cannot simply go on with "business as usual".

We should take a hard look at imposing a national health expenditure budget. The experience with Medicare's MVPS system suggests that this approach can work.

Our first witness today—I am sorry, Mr. Thomas, as usual, you have a statement.

Mr. THOMAS. As usual, I wasn't recognized for one. Thank you very much, Mr. Chairman.

Last Thursday, this Health Subcommittee conducted a hearing on part A budget issues. We heard from an array of provider groups who were willing to accept change that they believe is coming. But we are very concerned that Medicare cuts taken for budget purposes may not be consistent with reform. They were justifiably nervous that they would be asked to contribute now to deficit reduction as well as later to health reform.

The physicians under part B face the same problem. This is likely to be particularly worrisome to them because in 1989 they compromised with the Congress to adopt a whole new payment scheme for Medicare. This scheme is still in transition, and some of the President's proposals threaten the integrity of this transition.

Mr. Chairman, it is difficult to disregard their rightful concerns. However, we cannot escape the budget pressures which entitlement programs present to this Congress, nor can we ignore the fact that health reform may or may not come and may or may not provide a good vehicle to reduce the structural Federal deficit caused in large part by the growth in Federal health care costs.

These facts both illustrate the difficulties of the tasks before the subcommittee and the hard decisions we may have to make.

I hope as we make those decisions, we can find a balance that allows us to maintain a quality of care which our Medicare beneficiaries deserve, while, as I have pointed out, we continue to meet our fiduciary responsibilities as trustees of Medicare and the taxpayers' dollars.

I look forward to the testimony that is going to be presented. I thank the chairman.

Chairman STARK. Thank you.

We will now hear from William Toby, the Acting Administrator of the Health Care Financing Administration, Department of Health and Human Services.

Welcome to the committee, Mr. Toby. Your prepared testimony will appear in the record in its entirety, and I would appreciate it if you would expand on your written testimony or summarize it in any manner you are comfortable.

**STATEMENT OF WILLIAM TOBY, JR., ACTING ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. TOBY. Thank you, Mr. Chairman.

Members of the subcommittee, I am pleased to appear before you once again to address another component of the administration's downpayment for reforming our Nation's health care system. I will present our savings proposals for physician services, clinical laboratory services, and durable medical equipment.

During the last decade, the rate of growth in Medicare payments to physicians averaged about 11 percent a year. In 1992, physician services accounted for about 25 percent of total Medicare spending.

The administration has offered 13 proposals to curb spending for physician services and other components of part B of the Medicare program. We estimate these proposals will save about \$30 billion over the next 5 years. That is \$30 billion to redirect in the interest of the Nation's economy and in the interest of every American's health.

I discussed three of these proposals here last Thursday. I would like to outline the remaining 10 for you today.

Our first proposal deals with the part B premium. We would maintain current law through 1996. In 1997 and subsequent years, the premium would be set to finance the same proportion of program costs as was financed by the 1996 premium.

Chairman STARK. What would the premium be in 1998 given the present rate of inflation? About \$100 a month for seniors?

Mr. TOBY. I don't have that figure because I don't know what—

Chairman STARK. Don't you think the seniors would be interested in that figure?

Mr. TOBY. I would think so.

Chairman STARK. Let's say it is going to be about \$100 a month for their part B premium by then, and then you can make them happy if you think it is any lower. OK?

Mr. TOBY. OK.

Chairman STARK. Thank you.

Mr. TOBY. Thank you.

In 1997 and subsequent years, the premium would be set to finance the same proportion of program costs as was financed by the 1996 premium.

Our second proposal will reduce payments for clinical laboratory services. We propose to implement GAO's recommendation to lower the laboratory fee schedule caps from 88 to 76 percent of the median of all fees and then continue to update the revised fee schedules annually by 2 percent. In addition, the Secretary would be given the authority to make additional adjustments in Medicare rates to reflect technological changes, private market rates, and other factors. We estimate this proposal will save \$5.8 billion over 5 years.

Third, we propose to reduce physician fee updates in 1994 except for primary care.

Chairman STARK. Excuse me. Could you go back to that thing you slipped over about giving the Secretary authority to adjust rates? Tell us a little about that.

Mr. TOBY. Right. What we find is that there—

Chairman STARK. I don't care what you find. Tell me what the authority is that you are suggesting we give the Secretary. To adjust rates as the Secretary determines?

Mr. TOBY. Yes, based on market surveys.

Chairman STARK. Would you be doing this without congressional approval?

Mr. TOBY. Well, we, I would imagine—

Chairman STARK. Bag that, OK?

Mr. TOBY. We will be asking the Congress for approval for that, indeed. I don't think—

Chairman STARK. I don't think you are going to get it.

Mr. TOBY. OK. [Laughter.]

Mr. THOMAS. But we would certainly like to look at the work product.

Mr. TOBY. We will be happy to work closely with you on details as we have in the past.

Third, we propose to reduce physician fee updates, as I said, in 1994 except for primary care. In 1980, Medicare payments to physicians totaled \$7.8 billion. Last year, that number reached \$32.3 billion. We propose slowing this substantial growth by reducing the 1994 fee schedule update by 2 percentage points for nonprimary care services. We estimate a 5-year savings of \$1.7 billion if this proposal is enacted.

Our fourth proposal will develop a resource-based system for practice expenses under the physician fee schedule beginning in 1997, as recommended by the Physician Payment Review Commission. In the interim, we would reduce payments for selected procedures with high practice expense components. We anticipate a 5-year savings for this proposal of \$3 billion.

Fifth, we propose to revise the physician Medical Volume Performance Standard and the update default formulas. This proposal will lower the rate of growth to be more in line with recommendations made by the Physician Payment Review Commission. We estimate a savings of \$2.1 billion over the next 5 years for this proposal.

We hope our sixth proposal, bundling inpatient radiology, anesthesia, and pathology payments, will give physicians and hospitals incentives to provide only medically necessary services. We estimate this reform will save \$570 million over the next 5 years.

Our seventh proposal would establish a single fee for surgery. We propose to make the same Medicare payments for a surgical procedure regardless of whether the primary surgeon uses an assistant at surgery. Nationwide data suggests strongly that the use of assistants at surgery is related to variations in practice styles rather than the severity or complexity of specific patient cases. This proposal would result in a 5-year savings of \$510 million.

As you know, studies have demonstrated that physicians with ownership interests in clinical labs make referrals at higher rates than nonowners. Our eighth proposal will expand current clinical laboratory ownership and referral prohibitions to additional services such as: physical and occupational therapy, radiation, and durable medical equipment. We foresee that this proposal will help to reduce unnecessary utilization and save \$350 million over the next 5 years.

The ninth proposal would encourage the electronic submission of part B claims by charging \$1 per paper claim beginning January 1, 1996. We estimate this proposal will save \$440 million over 5 years.

Finally, we propose a package of reforms relating to durable medical equipment. These include tightening national limits, reclassifying certain items, restoring the authority of Medicare's contractors to adjust payments based on current prices. We estimate a 5-year savings of \$685 million for these proposals.

These savings proposals, along with the proposals I outlined for you last Thursday, represent a total savings of over \$53 billion. It was our intention to be as sensitive as possible when developing these proposals, especially where beneficiaries are concerned. We look forward to working with you on these proposals. But it will not be enough to merely slow the growth in the rate of Medicare spending. These savings are just the first step toward preparing our economy for comprehensive health care reform. We hope to work with you closely to implement these preliminary reforms and to aggressively pursue total reform of the health care system once the President presents his recommendations.

I thank you for this opportunity to present the administration's proposals. I will be happy to answer any questions, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF WILLIAM TOBY, JR.
Acting Administrator
Health Care Financing Administration

Mr. Chairman and members of the subcommittee:

I am pleased to appear before you once again to address another component of the Administration's down payment for reforming our Nation's health care system. At your request, I am here to present our savings proposals for physician services, clinical laboratory services and durable medical equipment.

What I said to you last Thursday bears repeating today. Medicare is one of the largest and fastest growing parts of the federal budget. Medicare growth is on a path that could soon surpass the budgets of defense and Social Security combined. Therefore, any serious attempt to reduce federal spending must include curbing the rapid growth in Medicare costs.

During the last decade, the rate of growth in Medicare payments to physicians averaged about 11 percent a year. And in 1992, physician services accounted for about 25 percent of total Medicare spending. While the physician fee schedule reforms are succeeding in distributing physician Medicare payments more equitably, further refinements and reforms in the methods we pay physicians are necessary.

The Administration has offered thirteen proposals to curb spending for physician services and other components of Part B of the Medicare program. We estimate these proposals will save about \$30 billion over the next five years. That's \$30 billion dollars to redirect in the interest of the Nation's economy and in the interest of every American's health.

I discussed three of these proposals last Thursday: extending the ten percent reduction on hospital capital payments for outpatient departments; reducing payments for the drug Epoetin; and extending and increasing the reduction in payments for certain hospital outpatient department services. I would like to outline the remaining ten for you today:

- **Maintain the Part B Premium as a Proportion of Program Costs.**
As you know, the Part B premiums for 1991 to 1995 were set in the 1990 Omnibus Budget Reconciliation Act at levels projected in 1990 to finance approximately 25 percent of Part B program costs. Our proposal would index the 1995 premium by the Social Security cost of living increase to establish the 1996 premium. In 1997 and subsequent years, the premium would be set to finance the same proportion of program costs as was financed by the 1996 premium.
- **Reduce Payments for Clinical Laboratory Services and Adjust Fees for Technological Change and Market Factors.** A GAO study released in June of 1991 indicates that Medicare payments to laboratories are excessive and higher than payments from other insurers. Therefore, we propose legislation to implement the GAO's recommendation to lower the Medicare laboratory fee schedule caps from 88 percent to 76 percent of the median of all fees. This revised fee schedule would be updated annually by 2 percent -- an extension of the current law established in the 1990 Omnibus Budget Reconciliation Act. Finally, the Secretary would be given authority to make additional adjustments in Medicare rates to reflect technological changes, rates in the private market, and other factors. We estimate these lab fee proposals will save \$5.8 billion over five years.
- **Reduce Physician Fee Updates in 1994 Except for Primary Care.**
In 1980, Medicare payments to physicians totalled \$7.8 billion. Last year, that number reached an astounding \$32.3 billion. We propose slowing this substantial growth by reducing the 1994 fee schedule update by two percentage points for non-primary care services. Because the Administration

believes more emphasis should be placed on primary care, primary care services are excluded from this proposal and would receive the full fee schedule update. We estimate a five-year savings of \$1.7 billion if this proposal is enacted.

- **Resource-Based Practice Expenses Development.** This proposal would develop a resource-based system for practice expenses under the physician fee schedule beginning in 1997 -- as recommended by the Physician Payment Review Commission. As an interim step toward such a system, we propose reducing practice expense relative value units in 1994, 1995 and 1996. A cushion on reductions would be provided while the methods and details for implementation are developed. The five-year savings for this proposal would be \$3 billion.
- **Reduce Physician MVPS and Update "Default" Formulas.** This proposal refines the method to set the Volume Performance Standard and future updates for physician services. Currently, in any year Congress does not set either the target for the rate of increase in Medicare physician expenditures, or the update, default formulas specified in law automatically apply. We propose reducing the target for fiscal year 1994 and thereafter by reducing the amount allowed by the default formula. The proposal would also allow larger reductions in the default update formula.

Currently, only modest reductions in the default MVPS are permitted. This proposal would lower the rate of growth to be more in line with recommendations made by the Physician Payment Review Commission. We estimate this proposal would save \$2.1 billion over the next five years.

- **Bundle Inpatient Radiology, Anesthesia and Pathology Payments.** Giving physicians and hospitals incentives to be cost-conscious, by providing only medically necessary services and eliminating the provision of marginal services, are overall goals of our proposal to bundle inpatient Medicare payments for radiology, anesthesia and pathology services. Payment would be made to the hospital, or its medical staff, which would then make payments to individual physicians. Beneficiary coinsurance would be 20 percent of the bundled payment. We estimate this structural reform would save \$570 million over the next five years.
- **Single Fee For Surgery.** Nationwide data strongly suggest that use of assistants-at-surgery is related to variations in practice styles of individual surgeons rather than the severity or complexity of specific patient cases. Therefore, we propose to make the same Medicare payment for a surgical procedure -- regardless of whether the primary surgeon uses an assistant-at-surgery. As a result, Medicare payment for the primary surgeon would be reduced by the amount of any separate payment for assistants-at-surgery. Exceptions would be allowed, if necessary, for particularly difficult cases. In addition to creating a level playing field between surgeons who do and do not use assistants-at-surgery, this proposal would result in a five-year savings of \$510 million.
- **Physician Ownership and Referral.** As you know, studies have demonstrated that physicians with ownership interests in clinical labs make referrals at a higher rate than non-owners. This proposal would extend current clinical laboratory ownership and referral prohibitions to additional services such as: physical and occupational therapy; radiology and other diagnostics; radiation therapy; durable medical equipment; and parenteral and enteral nutrition equipment and supplies. We foresee that extending the physician referral ban will help to reduce unnecessary utilization of these services and, as a result, save \$350 million over the next five years.

- Electronic Billing Incentive.** A total electronic billing system is critical to containing Medicare administrative costs. To encourage electronic submission of Medicare Part B claims, the Administration is proposing a \$1 charge per paper claim beginning January 1, 1996. This lead time will give physicians and suppliers time to adjust their systems or arrange to purchase electronic billing services. Our proposal would also lower limiting charges by \$1 to prohibit physicians and suppliers from passing on the cost to Medicare beneficiaries. We estimate this proposal will save \$440 million over five years.
- Durable Medical Equipment Proposals.** We have designed a package of savings proposals to reduce excessive variation in payment amounts and strengthen administration of the durable medical equipment benefit. Currently, payment for durable medical equipment is based on carrier fee schedules with national limits at the average value across all carriers. Our proposals to reduce payments for durable medical equipment include: tightening the national limits; reclassifying certain items; restoring the authority of Medicare's contractors to make adjustments to the fee schedules if payment amounts are grossly excessive or deficient based on current price information; and giving Medicare's contractors flexibility to require that the medical need of overused items be demonstrated in advance of delivery to the patient. In addition, the fee schedule for prosthetics and orthotics would be tightened by using the durable medical equipment payment rules with the national median as the limit. Finally, we propose establishing a fee schedule to pay for parenteral and enteral nutrients and supplies, and to pay for parenteral and enteral equipment under the same fee schedule and methodology used for durable medical equipment. We estimate a five year savings of \$685 million dollars if these durable medical equipment proposals are implemented.

These savings proposals, along with the Part A hospital savings I outlined for you last Thursday, represent a total savings of over \$53 billion dollars. As both the Secretary and I have emphasized to you over the last two weeks, this \$53 billion dollars will not cut current Medicare spending. But it will slow the growth from a 14 percent increase per year to an 11 percent increase. It was our intention to be as sensitive as possible when developing these proposals -- especially where beneficiaries are concerned. We look forward to working with you on these proposals and to receiving any suggestions you may have on further slowing this growth.

But it will not be enough to merely slow the growth in Medicare spending. These savings are just a first step toward preparing our economy for comprehensive health care reform. It is our hope to see the formation of a working partnership to implement these preliminary reforms and to aggressively pursue total reform of the health care system once the President presents his recommendations.

I commend this subcommittee for its serious and timely attention to this important subject. And, again, I thank you for these opportunities to present the Administration's proposals. Now I will be happy to answer your questions.

Chairman STARK. When will we see the details on these items, Mr. Toby?

Mr. TOBY. The President will be presenting his budget in early April.

Chairman STARK. And so you anticipate that in early April we will get the details explaining these cuts?

Mr. TOBY. That is right, sir.

Chairman STARK. All right. And I am sure you are aware, are you not, that at least in the past, when it has been suggested that the Secretary have discretionary authority to set rates, we get no budget scoring for that; that it has to be in legislation for the CBO to score the savings?

Mr. TOBY. That is right.

Chairman STARK. So if your plan to cut rates where you give the Secretary authority, and let's assume maybe half of that \$3.5 billion is on discretionary authority, we have to find some other savings if we adopted that plan because we couldn't score those savings. Would that not be correct?

Mr. TOBY. That is correct. We will work very closely with you on those matters.

Chairman STARK. Are you aware that postponing the update for all Medicare providers for 2 years would get maybe \$1 billion more in savings than the plan you propose?

Mr. TOBY. Are those CBO numbers?

Chairman STARK. Yes. Why wouldn't that be better?

Mr. TOBY. We——

Chairman STARK. You have an answer to that. You don't have an answer prepared by your staff to some of the other questions, correct?

Mr. TOBY. Oh, no, we——

Chairman STARK. But go ahead and read me the answer.

Mr. TOBY. We realize that for any complicated effort such as budget reduction, in terms of strategies, there will be a lot of ideas. One approach would be, of course, to have a freeze, in order to reduce outlays in future years. We believe, Mr. Chairman, that we have given tremendous thought and serious attention to the proposals that we are submitting to you, and we think they have enormous merit.

Chairman STARK. Would you quantify that tremendous thought in number of hours that were put in in the recent months into preparing this list? 6? 10?

Mr. TOBY. These proposals, as you know——

Chairman STARK. Excuse me. Number of hours. 6? 10?

Mr. TOBY. Well, many——

Chairman STARK. It is my understanding that it was determined overnight after the options were received from OMB. Is that about correct? Maybe 1 day?

Mr. TOBY. Most of the proposals in the total package grew out of reports that have been submitted by GAO and others in the past.

Chairman STARK. In the past. But the selection of those, that is a laundry list that is five times as long as this. The selection of those specific items was done overnight, was it not?

Mr. TOBY. No.

Chairman STARK. I beg your pardon?

Mr. TOBY. No, Mr. Chairman.

Chairman STARK. One day?

Mr. TOBY. Generally we gave tremendous——

Chairman STARK. No, not generally.

Mr. TOBY [continuing]. Thought——

Chairman STARK. In this list.

Mr. TOBY. This particular——

Chairman STARK. From the time the list was received from OMB until you selected these items, how much time elapsed?

Mr. TOBY. I would venture to say that——

Chairman STARK. I want you not to venture. I want you to state for the record, if you know it.

Mr. TOBY. It was several weeks, actually.

Chairman STARK. From the time you got the full list from OMB until the time you selected this list to send to Congress?

Mr. TOBY. It took several weeks.

Chairman STARK. And you are willing to stake your reputation on the accuracy of that remark?

Mr. TOBY. I participated in many of these discussions, and yes, I would. Several weeks.

Chairman STARK. All right. Thank you.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I want to ask a couple questions.

With respect to the RAP bundling, since radiologists and anesthesiologists do not initiate services but rather, they, respond to referrals from other physicians, how will the bundling of their services alter utilization to eliminate marginally useful services?

Mr. TOBY. As you know, under the current system, most physicians submit individual bills to us, and most utilization decisions are made by our carriers. With this proposal, we have basically given that decision to the medical staff. So we will make payments to the medical staff rather than make individual payments as we have in the past. We think this will give the medical staff an incentive to make decisions about the appropriateness of services.

Mr. MCDERMOTT. Then let me move to my second question, which is: If I understood your testimony correctly, you are making a uniform exclusion of assistants in surgery. Is that a fair characterization of what you have said?

Mr. TOBY. On assistants at surgery, under the current system we pay both surgeons and assistants. In many cases, we find the assistants-at-surgery tend to be primary care doctors, not surgeons. We are proposing to pay one fee regardless of whether the surgeon performs the procedure alone or chooses to use an assistant-at-surgery. We think that is not to the exclusion of the assistants. If the surgeon does choose to use an assistant, we are going to make separate payment to the assistant, and reduce the separate amount we pay to the surgeon.

Mr. MCDERMOTT. So you are not letting the physicians make that decision. You are making that decision: We are not paying for assistants. We will not pay for assistants.

Mr. TOBY. We are going to pay a single fee for surgery, and if the surgeon chooses to use an assistant-at-surgery, we will pay the amount separately and reduce our payment to the surgeon.

Mr. McDERMOTT. I see. The surgeon will split the fee with his assistant.

Mr. TOBY. The surgeon makes a decision about the payment.

Mr. McDERMOTT. You mean the physician makes the decision as to whether he needs an assistant, and if he makes the decision that he needs one, then you will pay for it?

Mr. TOBY. Our proposal has exceptions, such as the severity of cases or specific procedures. Our proposal applies to the discretionary cases where we have found that many times the cases are not so complex that you even need an assistant at surgery.

Mr. McDERMOTT. Well, I am not arguing whether or not every case it is an important thing. But when you make a blanket decision you are not going to pay for assistants, it sort of sounds like you are taking away from the physician any decision about whether he needs one or not.

Mr. TOBY. No. The surgeon will make that——

Mr. McDERMOTT. Yes, he can make the decision. You just won't pay for it.

Mr. TOBY. He can make the decision. The question has to do with payment.

Mr. McDERMOTT. Yes, of course. I understand. The guy can work for free. That is certainly in the Government's interest in saving money, but it may not be in the patient's best interest. So I think it really is an idea that needs to be thought about a little bit.

Mr. TOBY. We are just making a decision about payment. We are not trying to exclude the assistants from being there.

Mr. McDERMOTT. Yes, I understand you are not trying to make a medical decision, but somehow medical decisions get tied to money. There are two-tiered systems and three-tiered systems, and some people get things that others don't, primarily because there is money available to pay for it. I think that is what I find a little bit tough to accept in that kind of a blanket decision.

On the electronic billing incentive, don't you think the development of a uniform software for all payers really ought to precede the penalty for paper claims? I mean, until you have a uniform system, isn't it a little tough to penalize people before you have even got the software available?

Mr. TOBY. We have given the physicians 2 years to plan for this. We also find——

Mr. McDERMOTT. Beginning when? Excuse me.

Mr. TOBY. The \$1 charge per paper claim doesn't go into effect until 1996.

Mr. McDERMOTT. Oh, I see. From 1996 on——

Mr. TOBY. From 1994 to 1996 they have an opportunity to prepare for it. And I might also mention that under part A, for example, over 86 percent of our bills are already computerized and electronically transmitted, and under part B 58 percent. So basically in the industry, nationally there is a movement toward an electronic environment. We think this proposal is very consistent with these trends.

Mr. McDERMOTT. Like the Canadian and single-payer system. That is a good idea. I like the idea.

Mr. TOBY. Well, I have not seen Canadian data on this matter.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. McCRERY. No questions.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Toby, let's go back to the surgical assistants for a moment. It seems that the document outlining your proposal would—maybe I am reading it wrong, but it would seem to indicate that the primary surgeon will receive a reduced fee when an assistant is used, thereby paying for the assistant him- or herself. Would that be a correct assessment?

Mr. TOBY. No. I don't think that is a correct assessment.

Mr. KLECZKA. "The budget proposes to reduce the payment made to the primary surgeon on a case-by-case basis for any payments made to an assistant at surgery." That is what it smells like to me. It even sounds like that.

Mr. TOBY. Well, I think what would happen is that there would be a reduced payment in that instance.

Mr. KLECZKA. To the primary surgeon?

Mr. TOBY. That is right.

Mr. KLECZKA. And that reduced payment would only occur when an assistant was used?

Mr. TOBY. That is right.

Mr. KLECZKA. And so that would seem to me that the primary surgeon would be paying for his assistant out of his own reimbursement, maybe not totally, but in part.

Mr. TOBY. Well, there is a question as to—

Mr. KLECZKA. No. Would that be accurate?

Mr. TOBY. Well, I don't know whether he would be paying out of his pocket, but there are instances where—

Mr. KLECZKA. Well, if his reimbursement is reduced, it is—

Mr. TOBY. We are still determining conditions where we would pay and how much we would pay.

Mr. KLECZKA. Well, no. See, the problem with the proposal is, if the primary surgeon does not want a reduced reimbursement, he or she will choose not to use an assistant so as to maximize their own income, I would assume. I don't know if that is wise in all surgical procedures.

The other question I have relates to the testimony we are going to hear shortly from the AMA and also from the American College of Physicians regarding a proposal I support, which increases the reimbursement for primary care physicians. It is something that we are trying to encourage, not only in this program, but I think we are going to see a big dose of it in the national health care reform. As one who has made this proposal to the Congress, could you give us the rationale? Because you won't be here at the time of their testimony, answer their concern about reimbursing primary care physicians at a higher level.

Mr. TOBY. Well, as you probably know, we have been tilting our system for some time in favor of primary care because we want to

provide more incentives for primary care physicians. That is also an intent of the Medicare fee schedule.

Mr. KLECZKA. Why?

Mr. TOBY. Because we believe primary care physicians, from studies we have done, provide many more cognitive type services. They spend more time with the patients.

Mr. KLECZKA. More cost effective? This is a softball question. Come on.

Mr. TOBY. Yes. We certainly believe that the services primary care physicians provide probably will keep patients healthier and keep them out of hospitals where we pay a larger amount. So we have a strategy which we are implementing with some aggressiveness, and we want to continue to make investments. The President's investment package includes about \$196 million for increased efforts in primary and preventive care services. That is because primary care physicians tend to provide more preventive care.

Mr. KLECZKA. Let me just dwell on that for one moment. What would be your view of using the primary care physician as sort of the gatekeeper? Before a person could go to a specialist, they would have to be referred by a primary care physician—and this would drive the specialist crazy, naturally. They would either have to be referred to a specialist by a primary care physician after some treatment, or if it is above and beyond their level, the patient would get the referral immediately. What would be your view of that?

Mr. TOBY. Well, in which kind of a setting are you speaking of as a gatekeeper?

Mr. KLECZKA. Well, in the current system people often go immediately to the specialist, even though it might not be necessary to receive such a high level of care. All right? I can't give you a medical procedure. I will ask my physician colleague here for one later.

Mr. TOBY. Well, as you know, your question goes to the heart of one of the critical issues in this country; that is, how do we restructure our health care delivery system? Under health care reform, this issue is being reviewed in terms of structural reforms for the future. You might want to take a look at the health care reform package we will be submitting in May.

Mr. KLECZKA. Thank you. Very good advice. I might do that. [Laughter.]

Chairman STARK. Thank you, Mr. Toby.

Mr. TOBY. Thank you, sir.

Chairman STARK. Before calling the next panel, I would like to note the absence of Dr. Phil Lee, a professional who has worked with this committee certainly as long as I have chaired the committee. Dr. Lee has changed his venue. I am not sure he has left the good guys and gone to work for the bad guys, but he has announced that he will be working at Health and Human Services. We will miss him.

During the initial years, Phil guided the Commission through many difficult debates and helped this committee. The Commission made great strides and substantial contributions to our work. He helped us in determining the physician reimbursement program, and we owe him a debt of gratitude. He will be missed.

We are fortunate that his work is being continued by Dick Anderson, the Interim Chairman of the Physician Payment Review Commission. He will enlighten us today and will be accompanied by Paul Ginsburg, who also has enlightened us for many years and helped us in his work as the Executive Director of the Physician Payment Review Commission. We welcome both Mr. Anderson and Mr. Ginsburg to the committee this morning. We will ask you to begin to summarize your testimony, but first we will recess until 10 after the hour, try to vote, then return. Then we will be able to work straight through with you if that is agreeable. Thanks.

[Recess.]

Mr. CARDIN [presiding]. The subcommittee will reconvene.

Without objection, the entire written testimony of the witnesses will be made part of the full record.

Mr. Anderson, you may proceed as you wish.

STATEMENT OF RICHARD V. (DICK) ANDERSON, INTERIM CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY PAUL GINSBURG, PH.D., EXECUTIVE DIRECTOR

Mr. ANDERSON. Thank you very much, Mr. Chairman.

I want to also express my longstanding support of Phil Lee. He is from the same neck of the woods that I am. He was a mentor, and I will miss him, too, on the Commission.

I am very pleased to appear before you on behalf of the Physician Payment Review Commission to comment on part of the administration's proposed budget cuts. As in the past in hearings before Congress, we do not propose to discuss the overall magnitude of the budget cuts, but our interest is, given a specific target for budget cuts, we would like these to be most consistent with overall long-term policy goals.

Due to the limitations on time, I am only going to comment on four of the eight items that we have included in written testimony. First, I will start with the proposal to reform Medicare payments for direct medical education costs under part A of Medicare.

The administration's proposal has two components. One is to replace the existing hospital-specific payments for residents with a national average payment per resident, and the other has to do with giving more recognition in weighting toward primary care residents and less to others.

On the first of these, the Commission does have some concerns. We are instead proposing that a payment be based on a prospectively set national amount that is adjusted appropriately to recognize geographic differences in cost, and we are suggesting that the model for the adjustment be the part B GPCI's under Medicare. Also, if data warrant, we think that there could be adjustments, additional adjustments, for a year of training and for specialty.

We have problems with the proposal to weight primary care at a higher value on three grounds. One is that it is not likely to address the existing problem of having unfilled residencies for primary care physicians, and it is not likely to create a sufficient incentive for residency positions for specialists to be reduced. And also there is a question about long-term policy, whether we should embody in law a policy that will permanently give favorable treat-

ment to one class of physicians if later it is the case that other specialties become short.

The Commission has a comprehensive policy proposal for graduate medical education reform in its 1993 annual report. One of the features is that Congress would set limits on the number of residents overall. We are suggesting something along the following lines: It would be the number of U.S. medical graduates plus 10 percent. And also there would be provisions for how the distribution of the specialty slots would occur, including consideration of distribution based on quality of the educational programs.

Finally, we would want to ensure that there were protective mechanisms for hospitals, especially those in underserved areas, transitional relief for reductions in the residency slots.

Our proposal that is stated in the annual report would reduce overall payments to hospitals and would be consistent with the budget objectives. There would be fewer residents, there would be a lower per-resident cost, and there would be some other adjustments for indirect payments.

The second comment has to do with the administration proposal to reduce payment rates for all services by 2 percent except for primary care. We are assuming that the VPS mechanism will continue and that the approach would be basically to establish the update and then subtract 2 percent from it. The Commission has taken a consistent position that there be a single update for all services, regardless of whether they are surgical or nonsurgical services, and has not supported additional updates for other categories, including primary care.

However, in our recommendation this year in the annual report, we are proposing that if the separate updates for surgical and nonsurgical services be maintained, that we also then have a separate update for the broader category of evaluation and management services, not just primary care services.

The simplest approach would be to take the 1993 conversion factor for nonsurgical services—it is about \$31—and simply use that as the base for updates to 1994. That would come close to achieving the budget reduction target. If that isn't sufficient, the \$31 could be adjusted downward slightly.

Another administration budget proposal has to do with changing the default formulas, both for the MVPS and for the update. The administration is proposing to increase the size of the performance standard factor and also to increase limits on how much the MEI could be adjusted downward.

On the first of these, the proposal would be to increase the performance standard factor from the current level of 2 percent to about 4 percent by 1995.

Generally, the Commission supports this, but our approach in recent years has been different. Our target is to try and achieve growth, reduce growth to levels that are consistent with growth in gross domestic product, and I think our only proposal here is for legislation to specify a long-term projection of GDP as the default for the performance standards.

The other part of this proposal has to do with changing the update defaults. Currently, on the up side, there are no limits, and the down side is limited currently by 2.5 percentage points, a sub-

traction from the MEI. Under the administration's proposal, this would be increased to as high as 6 percent by 1996.

The Commission believes that 6 percent is too high, that the limit should be 5 percent, and that it also should be applied symmetrically, both on the up and down side, and this would promote more stability payments.

Finally, I would like to comment on the proposal to phase in earlier the resource-based practice expense approach that has been developed by the Commission. The administration's approach would be to establish screens that are related for practice expense components to the work components for the same services. The Commission has taken a position that the overall approach to resource-based practice expense should be delayed.

Implementation should not begin until 1997 for at least two reasons. One is that data currently are not adequate to set accurate relative values for practice expense, and also we would like to see that the transition under the work value part of the Medicare fee schedule be completed so we can fully understand the implications.

But we recognize that there are budget-cut targets for the next 4 years, and the Commission had to consider whether to have across-the-board cuts or to focus on practice expense as a way to achieve that budget reduction. The Commission does support the latter, provided that the administration's approach be adjusted in the following way:

We would propose that the screen for practice expense, overvalued practice expense components relating to the work values be limited only to the non-office-based services. Basically this would be justified because non-office-based services practice expense is mostly indirect costs, and under the Commission's methodology these vary with work values.

And so what we are proposing is that the administration approach be adopted for 1994, but the screens only be applied to the non-office-based services. And then when data are available—and we hope this will be by the beginning of 1995—the screens for reducing the overvalued practice expense components be then based on the practice expense methodology adopted by the Commission.

Finally, in 1997, we would propose that both reductions and increases in the practice expense components occur consistent with the methodology that we have proposed.

That is about all that I am going to comment on right now. I do appreciate the opportunity to appear before you. The staff is willing to support your work on these matters, and we are willing to take questions.

[The prepared statement follows:]

STATEMENT OF RICHARD V. (DICK) ANDERSON
Interim Chairman
Physician Payment Review Commission

Mr. Chairman, I am pleased to come before you to present the Physician Payment Review Commission's comments on the President's budget proposals that relate to physician payment under Medicare. Due to the timing, the Commission had to do a lot of its work by telephone. Although this posed less of a problem in considering proposals in areas in which the Commission has been actively working, in others our comments must be general, pending further opportunity for Commission discussion.

As in previous years, the Commission will not attempt to advise you about the overall magnitude of cuts in physician payment. Instead, we take as our assignment the following: if the Congress should decide to reduce spending for physicians' services in the Medicare program, how can that be done in a way that is most consistent with long-term policy goals.

The Commission has developed comments on one proposal to revise hospital payment (direct medical education) and seven proposals to revise physician payment.

REFORM MEDICARE PAYMENTS FOR DIRECT MEDICAL EDUCATION COSTS

The President has proposed revising the payment method for the direct costs of graduate medical education (GME). Currently, Medicare makes payments under Part A to hospitals for direct costs including residents' stipends and fringe benefits, faculty salaries, administrative expenses, and allocated institutional overhead. These payments are paid to teaching hospitals in addition to DRG payments and are based on hospital-specific per resident costs from the 1984 or 1985 cost-reporting years, updated for inflation.

The President's budget proposal has two components. First, it would replace hospital-specific calculation of per-resident payments with a GME payment based on a national average per resident amount. Second, through weighting, it would pay more than this amount for primary care residencies and less for others.

Prospectively Set Amount. The Commission will recommend a prospectively-set per resident payment in its forthcoming *Annual Report to Congress* as part of a comprehensive reform of graduate medical education. Hospital-specific calculation of payments under the current method has led to substantial variation in payments across hospitals, from a low of \$11,000 to more than \$100,000 per resident. This variation reflects differences in accounting practices, payments to supervisory physicians, and differences in efficiency, rather than inherent differences in the cost of training.

The Commission recommends that the prospectively set amount be less than the average of current payments, with the difference reflecting the results of past HCFA audits that have identified payments that were not appropriate. The amount should be uniform except for geographic variation determined by the physician work component of HCFA's geographic practice cost index (GPCI). HCFA could be given the authority to vary the prospective payment on the basis of year of training and specialty if supported by data on costs.

Weighting. We estimate that the President's proposal for weighting would increase the average payment for primary care residents by 12 percent, while reducing payment for other residents in their initial training period by 35 percent and for all other residents by 53 percent.

Although the Commission supports the goal of increasing the proportion of physicians trained in generalist fields, it does not consider weighting proposals to be the most effective means to achieve that goal for several reasons. First, creation of additional residency positions in primary care appears unnecessary because there are many existing unfilled slots in these fields. Second, weighting would likely not have a large enough financial impact on hospitals to induce significant reductions in specialty residency positions. Third, despite the current call to increase the proportion of generalists, the nation will continue to require well-trained physicians in all specialties. Paying substantially less than the costs of specialty residencies may not be a wise policy over the

long term. The Commission favors limiting the number of positions funded, but funding each of those adequately for the full length of training.

The Commission's *Annual Report to Congress* describes a comprehensive policy for financing graduate medical education that is intended to result in a system of graduate medical education that is more responsive to societal needs. Briefly, this policy includes:

- a congressionally set limit on the total number of residencies to be funded, for example, U.S. medical graduates plus 10 percent;
- a federal body that, using both objective data and input from interested parties, would determine the distribution of these slots by specialty;
- decisions by accrediting bodies to select those residency slots to be funded on the basis of educational quality;
- payments for the direct costs of GME to approved residencies from a national financing pool to which all payers would contribute a percentage of premiums or payments for medical care services; and
- mechanisms to provide transitional financial relief to teaching hospitals that lose residents but still must meet essential service needs.

While conceived as a possible component of health system reform, the Medicare elements of the policy would reduce outlays. Reductions would come from making direct medical education payments for fewer residents, from a lower per resident amount (described above), and from lower ratios of interns and residents per bed in the formula to compute indirect medical education payments.

REDUCE PAYMENT RATES FOR ALL SERVICES EXCEPT FOR PRIMARY CARE

The Administration is proposing a 2 percentage point reduction for all services except primary care (mostly office visits). As we understand it, the proposal would not suspend the process for setting the conversion factor update though the Volume Performance Standard (VPS). Rather, it would subtract 2 percentage points from whatever update was determined.

This proposal differs from an across-the-board cut by exempting primary care services. The Commission made such a distinction in its budget recommendations in years prior to enactment of the Medicare Fee Schedule and the Congress provided higher updates for primary care services in OBRA87 and OBRA89.

The context now differs, however. Distortions in relative payment between primary care services and other services have been addressed through the Medicare Fee Schedule. The Commission favors a uniform update for all physicians' services. If the Congress continues the surgical and nonsurgical distinction in the VPS, the Commission recommends a separate VPS for evaluation and management (EM) services. The Commission opposes establishing still another conversion factor for primary care.

Last spring, the Commission recommended that the differential update for 1993 (0.8 percent for nonsurgery, 3.1 percent for surgery) should apply to that year only and not affect payment in later years. This could be accomplished by using the 1993 conversion factor for nonsurgery (\$31.25) as the base for the 1994 update for both nonsurgical and surgical services. Although this would not save as much as the President's proposal, the savings could be increased to that level by lowering the base for the 1994 update slightly from the \$31.25 figure.

REDUCE PHYSICIAN MVPS AND UPDATE "DEFAULT" FORMULAS

This proposal would reduce the default performance standards for Fiscal Year 1994 and thereafter by increasing the size of the performance standard adjustment factor. In addition, the limits on reductions from the MEI in the default formula would be increased.

Changing the Performance Standard Defaults

As specified by OBRA89, the performance standard default formula is the product of four factors minus the performance standard adjustment factor. The performance standard adjustment factor is currently set at 2.0 percentage points. Under the proposed change, this factor would be increased to 3.5 percentage points for 1994, and 4.0 percentage points for all subsequent years.

The Commission supports changes to reduce this default formula in order to cut spending. As the Commission has developed its annual recommendations to the Congress on the VPS, it has consistently recommended a performance standard that is lower than the default standard in current law.

The specific adjustment factors proposed by the President are consistent with the Commission's practice of basing its recommendations on the principle of slowing the rate of growth of spending to the rate of growth of gross domestic product (GDP) by 1996 (after adjustment for the more rapid growth in the Medicare population). Our only suggestion is for the legislation to specify a long term projection in GDP as the default for the performance standard.

Changing the Update Defaults

Under the default formula, the update is determined by subtracting the difference between actual expenditure increases and the performance standard from the Medicare Economic Index (MEI). The amount that can be subtracted is limited to 2.5 percentage points for the update for 1994 and 3.0 percentage points for subsequent years. The proposal is to increase this limit to 5.0 percentage points for the update for 1996 and to 6.0 percentage points for subsequent years.

The Commission endorses the concept of increasing these limits, but recommends two modifications. First, a limit of 6.0 percentage points is too high. One of 5.0 percentage points would be preferable. Second, these limits should be symmetric. Given the large variation in year-to-year rates, it would be appropriate to have the same limits on amounts that can be added to the MEI. Thus, the Commission recommends 5.0 percentage point limits on additions or subtractions to the MEI effective with the update for 1996.

RESOURCE-BASED PRACTICE EXPENSE PHASE-IN

A very important component of the President's proposals that affect physician payment, from the perspective of both budget savings and policy, is the one to phase in resource-based practice expense (RBPE). Citing the Commission's work to develop a resource-based methodology for practice expense, the Administration proposes a transition to that policy of reducing practice-expense relative values for services in which the ratio to the physician work value is particularly high.

The Commission's methodology for RBPE involves estimating the direct and indirect costs for providing each service. Direct costs, which can be linked to the provision of specific services, are measured through industrial engineering methods. Indirect costs, such as office rent and salaries of nonclinical personnel, are allocated in proportion to the sum of direct costs and physician work. In its *1993 Annual Report to Congress*, the Commission recommends that a transition to RBPE begin in 1997. The delay reflects both the desire

to complete the transition to the Medicare Fee Schedule before embarking on further restructuring of the pattern of payment and the time needed for collection of additional data on direct costs.

With a requirement for budget savings this year, the Commission had to consider whether to recommend obtaining a portion of that savings by targeting those services anticipated to be reduced under RBPE. Good arguments can be made for either making across-the-board cuts to obtain all of the savings or obtaining a portion of the savings in a way that changes the structure of payment toward the that envisioned for the future. The Commission recommends the latter.

We then considered whether the Administration's proposal is the best way to accomplish this. The proposal should be evaluated on two grounds: how closely the transition tracks the changes in relative payment under the RBPE methodology and how much additional payment restructuring and redistribution is appropriate. The Commission has simulated the Administration's proposal, comparing its payment rates for 1996 with those under current policy and those under the Commission's method for RBPE.

The Administration's proposal would cause significant reductions in payments for some services and specialties (Table 1). For example, services accounting for 12 percent of physician payments would have their payment rate reduced by 15 percent or more by 1996. Services accounting for 0.5 percent of payments would be reduced by 35 percent or more. Diagnostic services would bear the brunt of these reductions, with an 11 percent cut, with global surgical procedures cut 8 percent. At the specialty level, ophthalmology would experience a 10 percent reduction, with cardiology, thoracic surgery, and orthopedic surgery experiencing reductions of 5 percent.

When viewed as a transition to RBPE, the Administration's proposal would be uneven. To assess this, we calibrated the Commission's RBPE method to be budget neutral with the Administration's proposal. Diagnostic procedures would experience 32 percent of the eventual cut while global surgical procedures would experience only 18 percent of their ultimate cut (Table 2).¹

At the level of individual services, a significant minority would have practice expense relative values reduced to a level below that under RBPE. Of the 300 office-based services covered by the Commission's pilot study of its RBPE method, 10 would be cut to levels below their RBPE levels.

The Commission also has concerns with the fact that this proposal would draw all of its payment reductions from the practice expense component of the relative value scale. The three components of the scale--physician work, practice expense, and malpractice expense--were calibrated to reflect data from physician surveys on shares of revenues from patient care. To draw large payment reductions from only one component would distort the relative weights of these three components. The result would be an underpayment of services for which resource-based practice expense is large in relation to physician work and an overpayment for services with relatively large physician work components.

We have developed an alternative to the Administration's proposal. First, only services provided in settings other than the office would be screened by comparing practice expense relative values with work relative values. For services in nonoffice settings, most practice expense is indirect costs. Under the RBPE method, indirect costs are allocated in proportion to direct costs and work. Thus, for these services, the Administration's proposal is very close to the Commission's method. For office services, many of which have substantial direct costs, physician work is not a good proxy for total practice expense.

¹ Many diagnostic procedures are excluded from possible reduction in the Administration's proposal. For those not excluded, the percentage would be much higher

Thus, by limiting the proposal to nonoffice services, it is applied only to services for which it is appropriate.

Our preliminary simulations suggest that this modification would eliminate all of the cases in which practice expense relative values are reduced below projected levels under RBPE. The sharp reduction in payment for diagnostic services as a group would also be lower. Approximately 10 percent of the savings would be lost. These could be recovered by either a uniform adjustment in work values (this would partially address the issue of too much of the savings coming from the practice expense component) or an adjustment to the conversion factor.

For the second and third years in which this transition is in effect, we recommend that HCFA substitute screens based on the Commission's RBPE methodology. We understand that the micro-costing study by the Center for Health Policy Studies that covers 48 physician group practices will be completed shortly. The results might well permit HCFA to develop screens based on projected RBPE values in time for January 1995 implementation. With such data, services in all settings could be screened for possible reductions in practice expense relative values.

Finally, we recommend that by 1997, this transition involving only payment reductions end and a transition to the full RBPE policy, which would involve payment increases as well as decreases, begin.

As the Commission has worked on methods to pay for practice expense, it has conducted parallel efforts to pay for malpractice expense. The 1993 Annual Report to Congress includes a recommendation to adopt a risk of service (ROS) method to pay for malpractice. RBPE and ROS share conceptual underpinnings and are also linked in the sense that specialties that have payments reduced under RBPE tend to have payment increases under ROS. The Commission has considered a parallel transition to ROS payment to reduce spending but has not had the time to develop a proposal. Nevertheless, it urges that if the Congress enacts a transition to resource-based practice expenses that it also enact ROS payment for malpractice expense.

DRG PAYMENT FOR INPATIENT SERVICES OF RAPs

The Administration has proposed to bundle payments for all of the inpatient services of radiologists, anesthesiologists, certified registered nurse anesthetists, and pathologists at a hospital into a single DRG-based payment. Payment would be based on the national average Medicare Fee Schedule payments for all beneficiaries admitted to hospitals for a specific DRG. If the hospital medical staff met certain qualifications to receive the payment, it could elect to do so. Otherwise, the payment would go to the hospitals.

When the Reagan Administration made a similar proposal in 1987, the Commission did not support it. Some of the problems with the earlier proposal have been solved. Nevertheless, the proposal would profoundly affect the complex relationships between hospitals and physicians and the Commission would want to devote considerable study to it before making a recommendation.

Instead, the Commission recommends a reform in payment for anesthesia care delivered by a team comprised of a certified registered nurse anesthetist (CRNA) and an anesthesiologist. Currently, Medicare pays 20-30 percent more for services delivered by a team than for those delivered by a solo anesthesiologist. Payments to anesthesia care teams should be capped at 120 percent of the payment to the solo anesthesiologist, declining 5 percentage points a year until reaching 100 percent. The payment to the team should be split so that each practitioner receives 50 percent.

The Commission also notes that radiology services have a slower transition to the Medicare Fee Schedule than is the case for physicians of other specialties. As an alternative to the DRG proposal, the Congress might consider a speedup of this transition to be more consistent with the standard transition.

ASSISTANTS-AT-SURGERY

The Administration's proposed budget reductions for assistants-at-surgery would require the Department of Health and Human Services (HHS) to identify certain procedures and types of patients that require a physician as an assistant-at-surgery. In all other instances in which an assistant-at-surgery bills Medicare, the primary surgeon's payment would be reduced by the amount paid to the assistant.

In recent years, payments to assistants-at-surgery have been reduced substantially. Under OBRA90, payments to assistants-at-surgery were reduced 20 percent, and procedures with physicians' billing as an assistant-at-surgery less than 5 percent of the time nationwide were excluded from payment. In addition, policies such as overvalued procedures and implementation of the Medicare Fee Schedule have reduced payments further by reducing payment rates for surgery that payment for assistants is tied to. From 1990 to 1991, this reduced Medicare's spending for assistants-at-surgery by almost half. In 1992, payments to assistants-at-surgery appear to have declined another 7.5 percent.

With payment for assistants already reduced by more than half, the Commission is reluctant to recommend further cuts without first assessing the impact of previous policies. The Commission plans to analyze data for 1992 over the next few months to assess the impact of these recent policies.

The Commission nevertheless encourages HHS, in consultation with the surgical specialty societies, to identify those procedures and types of patients which require a physician as an assistant-at-surgery. Such guidelines, even without restrictions on payment, might encourage more appropriate use of assistants by reducing some of the variation in practice style.

BANNING PHYSICIAN SELF-REFERRALS

The Commission has not done significant work on the issue of physician self-referral and thus cannot provide detailed advice on the Administration's proposal. We are aware of the recent research literature and its findings of large differences in rates of use between referral when the physician has no financial ties and self referral. Given the need for cost containment, legislation in this area is a priority, with application to private as well as governmental payers desirable.

ELECTRONIC BILLING INCENTIVE

This proposal would encourage more physicians to submit Part B claims electronically by charging a \$1 penalty per paper claim. Recognizing that some physicians may need time to switch to electronic billing, the penalty would not go into effect until January 1996.

The Commission supports expanded use of electronic billing but has concerns with this approach. With the Medicare program having recently required physicians to submit all claims for Medicare patients, the \$1 charge for paper claims appears to impose a significant "hassle" on some physicians that would produce only a limited gain for the program. Physicians most impacted by the charge would be solo practitioners with low volumes of Medicare patients who perform mostly low-priced services, such as visits.

Instead we suggest a number of steps to ease physician adoption of electronic billing. For example, the Congress could require use of a common electronic standard to be used by

all insurers, including Medicare. This would reduce the fixed costs to physicians of adopting electronic billing.

CONCLUSION

I hope that these comments will be helpful to the Committee as it prepares to write legislation to meet the targets established by the budget resolution under tight time constraints. The Commission and its staff are prepared to work further with you in this process.

Table 1. Impact of Administration's proposal for transition to resource-based practice expense, by service family and by specialty

Percentage change	
Family	
Evaluation and management	0
Diagnostic procedure	-10
Therapeutic procedure	-4
Surgical global	-8
Specialty	
Cardiology	-5
Family/general practice	0
Gastroenterology	-4
Internal medicine	-1
Other medicine	0
General surgery	-1
Dermatology	0
Ophthalmology	-11
Orthopaedic surgery	-5
Thoracic surgery	-5
Urology	-1
Other surgery	-2
Other (not RAPs)	-1
Total	-3

Table 2. Comparison of Administration proposal and Commission's RBPE method with current law^a

Percentage change

	Administration	RBPE method
Family		
Evaluation and management	+2	+11
Diagnostic procedure	-6	-19
Therapeutic procedure	-1	0
Surgical global	-5	-28
Specialty		
Cardiology	-2	-10
Family/general practice	+2	+12
Gastroenterology	-1	-16
Internal medicine	+2	+5
Other medicine	+2	+5
General surgery	+2	-6
Dermatology	+3	+23
Ophthalmology	-8	-11
Orthopaedic surgery	-2	-12
Thoracic surgery	-2	-21
Urology	+2	-3
Other surgery	+1	-1
Other (not RAPs)	+1	+8
Total	0	0

^aTo facilitate comparisons, each option and current law reflects savings from Administration proposal.

Mr. CARDIN. Mr. Anderson, let me thank you for your comprehensive testimony.

Dr. Ginsburg, did you want to add anything?

Mr. GINSBURG. No. I think he covered it all. I would be glad to help with questions.

Mr. CARDIN. Well, we thank you for your comprehensive testimony.

Let me ask you a question, if I might. You point out, as many witnesses before this committee have pointed out, the need to look at the way that we train physicians as far as their specialties are concerned so that we can have a better mix in regards to health care reform, particularly more trained in primary health care fields.

You also indicated there are many strategies that could be used to try to deal with training more physicians in primary health care.

I am wondering whether the Commission has any information as to what impact the reimbursement system could have on influencing medical students to train in primary health care fields or for physicians to practice in primary health care fields, whether the reimbursement rates have much influence on those decisions or not and whether you have information on the Commission that could be useful to us in that regard.

Mr. ANDERSON. My own understanding of the situation is that reimbursement rates do have an effect. We are changing, as you know, to a resource-based fee schedule, the Medicare fee schedule, to provide more appropriate incentives for primary care physicians.

The changes that are being proposed for graduate medical education also involve changes in reimbursement that in a general way will be more conducive to training generalists.

But I don't know that we really have a good understanding from my perspective of the effects of reimbursement changes on decisions to practice in primary care.

Mr. GINSBURG. If I can add something, so far, of course, we have only changed the structure of payment for Medicare, and that only accounts for perhaps 30 percent of a typical physician's practice load. While there are encouraging signs about private payers and Medicaid programs moving toward the Medicare structure, still most of the payment is based on the old charge-based system. Since we have not put out the full incentives yet, we do not know how far it will go. I see reform of the financing of graduate medical education as a distinct policy, a supply-side policy that complements a demand-side policy to get a larger and a faster change in the mix of specialties that we are training.

Mr. CARDIN. Dr. Ginsburg, you may have given me one more additional reason why we should consider an all-payer rate system so that we could control the entire activity in addition to Medicare.

Can we move forward in reforms in regards to training of physicians in primary health care absent the overall health care reform proposals that are being discussed?

Mr. ANDERSON. Well, I think we can. Clearly, graduate medical education reform is a component of broader health care reform generally, and it need not be delayed or tied into other aspects of reform. From my perspective, the sooner the better start in this area.

Mr. CARDIN. Your statement mentions the problems of self-referrals by physicians, but you point out the Commission hasn't done a good deal of work in this areas, but you call for action. I was curious as to why you are calling for action if you haven't done much work. Is it evident, the problem that is there, and that we need to take action on self-referrals?

Mr. ANDERSON. The Commission in principle strongly supports reform in this area. We simply have not had any staff work in this area, and the Commission has not had an opportunity to discuss the details of reform options. In a conversation by telephone last week, Commissioners did, however, agree to some kind of a legislative authority to have further reform in existing levels of constraints.

Mr. CARDIN. Thank you.

Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I would like to ask you about the GME change. What impact do you think it will have on hospital services? I had a delegation from New York come down and talk about the disastrous effects to the public hospital system in New York City. But I think that it is true across the country, especially in all-payer States where you have no ability to shift costs in hospitals. How are you going to have staffing for the major hospitals in major urban areas if you do what you are proposing to do to GME?

Mr. ANDERSON. Well, as I mentioned in the testimony, Mr. McDermott, we are proposing transitional relief for teaching hos-

pitals, especially in the areas that are underserved. The nature of the transitional relief can be determined based on need.

I guess at some point if there has to be special provision for maintaining service in these areas, Congress can take additional action to specifically to earmark to address that problem.

Mr. GINSBURG. If I can add something, we have talked about both versions of this proposal that would be a part of health care reform and then versions that are only revisions to Medicare. Clearly you can be more aggressive with this policy in the context of health care reform, because in that situation these inner-city hospitals would all of a sudden have paying patients, and—

Mr. McDERMOTT. I think that is precisely my problem. Making this cut by itself, without overall reform, is going to distort the problems in inner cities tremendously. I am really worried about doing this. If you say you are going to give relief from this cutback on a need basis, I think the line will start right here and will go from New York to Chicago, to Detroit, to Cleveland, to Atlanta, to Los Angeles. Every major city is going to have their people right here in line.

Don't you believe that?

Mr. GINSBURG. The magnitude of the reduction we are talking about and the number of positions funded isn't that large. We would start with the first-year residents, and it would move through. So it would take effect quite gradually. And given the fact that we are saving money for each position that we don't fund, in a sense that seems to generate possibly ample supply of funds to provide relief to those institutions that both serve a significant indigent population and also turn out to have lost a lot of their funded slots.

Mr. McDERMOTT. So your view is that it will take money out of suburban hospitals or nonpublic hospitals and shift it to the public hospitals. That is basically the shifting you are talking about?

Mr. GINSBURG. Given the money you are taking out of hospitals, you will have an ample base to fund the hospitals that lose the positions that are going to have difficulty hiring physicians or nurse practitioners to take the place of the residents.

Mr. McDERMOTT. I guess I doubt that, and I guess we will see as we go down the road. But I want to ask a second question relating to this whole business of selecting residencies to fund on the basis of quality. Can you explain? Give me some idea how you are going to judge quality of a residency.

Mr. GINSBURG. I am not anticipating that the Government would do it. But we have an infrastructure of specialty boards that are now accrediting residency programs that could be called on to help.

Mr. McDERMOTT. So the boards would say we will fund the Georgetown residency in surgery, but, George Washington, you don't get any residencies?

Mr. GINSBURG. The board would rank these programs as to its judgments of quality, and then the Government would presumably use those rankings to make its funding decisions.

Mr. McDERMOTT. So the American Board of Surgeons would set theirs, and the American Board of Cardiology would make theirs, and the OB/GYN people would make their own?

Mr. GINSBURG. Generally, that way. They would be part of an overall infrastructure and would have to defend their choices to their colleagues in other specialties. But the real responsibility would be placed on these professional accrediting bodies. In some of the surgical specialties, we have a history of those bodies closing a number of programs on the basis of their not meeting quality standards. For that reason, in these specialties the number of surgical residencies has actually not grown much at all.

Mr. McDERMOTT. I guess my question, then, is one level up from that. Who would make the decision about how many surgeons we need and how many cardiologists? Who would make that decision?

Mr. GINSBURG. That is right. We have envisioned some governmental body making this decision. It could be some board in the Department of Health and Human Services. If there were an independent Federal health board created as part of the health care reform legislation, it could be that board or a subsidiary of that that made these decisions. But we see them as public decisions.

We see the Congress setting the overall target as far as the overall number of residencies that the government would fund and having some commission or board actually making the decisions specialty by specialty, and then turning to the profession to rank the programs.

Mr. McDERMOTT. So we will assume that sometime in the near future we will have a national health plan, but before that, you have no other body selected that would do that in the near term?

Mr. GINSBURG. Yes. If you were passing this legislation independent of health care reform, you could either give that responsibility to the Department of Health and Human Services, or perhaps create a special commission or board with just those responsibilities.

Mr. McDERMOTT. Let me go to one other thing, because I listen to these ideas about how you are going to get physicians to choose primary care as opposed to a specialty. And when the average in public medical school debt, the average medical student coming out is somewhere around \$60,000 in debt, and a private medical school it is somewhere close to \$100,000, do you see any incentive in anything you are talking about that is really going to change the decision by medical students to get out and get a professional specialty that pays off that debt?

Mr. GINSBURG. Well, I see a series of incentives. First, as Mr. Cardin mentioned, the restructuring of payment would reduce the attractiveness of specialties in relation to primary care. Then, if you limited the number of slots, there would be some physicians that might want to choose a specialty but wouldn't find a slot to get into, and they would have to follow what might be their second choice.

The Commission has discussed medical student debt. Even though these numbers sound high, if you compare them to the earning stream that you would expect, even for primary care physicians, the debt it does not seem to be a big amount. I think the real problem is that the students have to start paying the debt back so soon, while they are still in their residency years, when it is very difficult for them.

If we were to have some type of reform on debt, the key thing to emphasize would be allowing physicians to get into practice before they have to start this payback.

Mr. McDERMOTT. When I got out of medical school, I was \$500 in debt, and I did not choose a specialty on the basis of paying off a big debt. I think it is a big driver today. And I believe you are creating a real problem if you say we are going to limit the number of specialty slots, but people are still going to get out of the medical school \$100,000 in debt and there is no place to go to make it back. If you go out into general practice, you will be paying it off when you are 75 years old. That is not the kind of incentive that is going to get the best people going into medicine. I really think that issue has to be addressed.

It may be through the debt structures you suggest that somehow you allow people to pay off on the basis of some proportion of their income or something else. But if you are expecting somebody to come out of medical school and start paying the debt off while they are in residency, which is what is presently going on, you are just driving anybody who thinks about it out of the profession. I think it is a serious disincentive to go into medicine, and I think it is one that has to be considered in any kind of reform program.

Thank you, Mr. Chairman.

Chairman STARK [presiding]. Mr. Levin.

Mr. LEVIN. Thank you.

Let me just ask you a bit about following up what Jim McDermott has questioned about, about medical education. As I understand it, you are proposing that instead of our present system, which is kind of a hodgepodge, that we really set some limits by specialties and let some mechanism, some entity carry out those numbers? Is that it?

Mr. ANDERSON. That is basically it.

Mr. LEVIN. That is done in Canada, is it, more or less? Do you know?

Mr. GINSBURG. I believe so.

Mr. LEVIN. Well, we will take the best out of your proposal, Jim.

If you would, give me the strongest argument against your proposal. Let me ask you to because Jim McDermott and others have raised this issue. I think it is correct for us to do some real focusing on the issue of training and supply of health care professionals. We will also ask this of the witnesses who are coming after you—some of them will surely disagree.

Mr. ANDERSON. I don't know that this would qualify as an argument against, but I suspect that there are many in this room that would be concerned about whether we will have an adequate stream of physicians for the year 2000 and beyond if we now take precipitous steps that might be regarded as arbitrary to limit residency positions and slots and allocate them in certain ways.

Having said that, my own level of concern is about the rate of increase of physicians. My understanding is that we are turning out physicians at twice the rate of population growth. And we all know that not only do physicians generate their own tax on national incomes somewhere on the order of \$150,000 to \$200,000 now, but as the chairman pointed out earlier, the additional 80 percent that they generate. So the question is: Do we really have an

excess currently, and how do we maintain sustainable increases in the right kinds of doctors?

Mr. LEVIN. Dr. Ginsburg, any comment? Why not do it through the incentive structure strictly?

Mr. GINSBURG. You mean the incentive structure of the relative incomes in different specialties?

Mr. LEVIN. Well, and also in terms of how we fund the slots, the support that we now give. I mean, a number of us have been working on dramatic changes in that. A surgeon told me last week that whatever we did would not matter, because in some cases there are vacancies in slots where the reimbursement to the facility is higher than to any other specialty.

But why not do it through incentives?

Mr. GINSBURG. Well, I think there are two concerns about—

Mr. LEVIN. Managed competition.

Mr. GINSBURG. What I was going to say is that if you were getting at the incentives to the teaching programs by having the Medicare program pay more generously for primary care residencies and paying, say, a lot less than cost for other residencies, there are two problems.

One is whether those incentives are strong enough to get significant effects and the risk that you could do this and turn around 5 years later and decide that nothing has been accomplished you have lost 5 years.

The other problem is that even though we have an imbalance in specialties, we clearly still need specialists to be trained in the future, and if we, across the board, always pay much less than program costs for specialty training in good institutions, in poor institutions, we may be sending the wrong signal about our willingness to support graduate medical education. We could even wind up, say, inadvertently creating shortage problems in some areas where they do not exist today.

Mr. LEVIN. Thank you.

Mr. ANDERSON. Mr. Levin, I would just like to add that one could suggest that there are some elements of managed competition in the proposal of the commission. One of the earmarks of managed competition is cost-conscious choice and incentives to improve quality, and especially in the latter area, we are presuming that accrediting agencies will establish distributions of slots, decisions based on quality, and I also think that there are elements of cost-conscious choice that are consistent.

Mr. LEVIN. But the issue is not only one of quality, right? It is one of overall numbers.

Mr. ANDERSON. That is correct.

Mr. LEVIN. Thank you.

Chairman STARK. Thank you. We will be having some discussion later today on practice expenses or resource-based practice expense. And I just want to restate what I understand the position is we are in.

When we wrote the physician reimbursement plan, all the adjustment and the negotiation for the update and index is on the part of the physician's reimbursement that goes strictly to that physician's personal professional service. And then there was a second component that I will just call overhead; you might call it

something else. But it deals with rent, supplies and assistant's and nurse's salaries, everything except malpractice insurance.

And it was in the initial bill that we decided, in effect, to reimburse that basically at cost, or as near cost as we could determine. I mean, not to try and make a difference between a pediatrician's overhead and a neurosurgeon's overhead; whatever they spent, we pretty much reimbursed at cost.

Is that a fair—

Mr. ANDERSON. Well, the current OBRA 1989 approach really recognizes the cost as reflected in traditional charges for these services, and there are substantial inequities.

Chairman STARK. I understand. I am just trying to get to where we are.

Mr. ANDERSON. Right.

Chairman STARK. Is it a fair assessment to say that we are pretty much reimbursing on a cost basis or a historic basis?

Mr. GINSBURG. I would say that we are paying on a historical charge basis.

Chairman STARK. OK. And how do we adjust that currently, just according to inflation or—

Mr. GINSBURG. Yes. As we update the conversion factor.

Chairman STARK. If we go up 4 percent, overhead goes up 4 percent?

Mr. GINSBURG. That is right.

Chairman STARK. And that was depending on the specialty, around half. Is that a fair assessment?

Mr. GINSBURG. Yes.

Chairman STARK. Now what you are recommending is that because there is a major difference in the overhead component as a percentage of the total fee, depending on what kind of a practice it is, we ought to scale those reimbursements for overhead on some relationship to the type of practice or its relationship to the overall fee. Is that what you are recommending?

Mr. ANDERSON. That is the administration proposal, and we are supporting that for 1994.

Chairman STARK. Now when we set the professional fee, that action was preceded by several years of the Hsiao study in which the physicians participated and were perhaps the determining factor in dividing those professional fee resource-based relative values; is that not correct?

Mr. ANDERSON. That is correct.

Chairman STARK. But what we are suggesting today on the overhead side has, in relation to that, precious little data and precious little negotiation on the part of the specialty involved. Is that a fair assessment?

Mr. ANDERSON. I am not sure that I would agree with that, Mr. Chairman. We have had, in the commission, about 3 years of work on developing the resource-based practice expense approach, and there has been a substantial amount of data from certain parts of practices analyzed already. Also the Center for Health Policy Studies has reasonably good information now, and it is evolving on about 50 more clinical practices.

Chairman STARK. I do not mean to question your good research, but it is my understanding that under the previous Hsiao study at

least there was an equilibrium in the acceptance of that study by the physician community, and they participated. I do not know how they selected the participants, just like I do not know what is going on in the White House, but there is some magic formula that got all the doctors into the act.

What I am sensing is that all of the doctors have not come to a consensus that this is a fair way to allocate the overhead part of their fees.

Am I reading that right?

Mr. ANDERSON. There is clearly not consensus on that.

Chairman STARK. What would be wrong—

Mr. GINSBURG. Excuse me, Mr. Chairman.

Chairman STARK. Go ahead.

Mr. GINSBURG. The comments delivered at this hearing by various specialty groups recall to me very much the way it sounded in 1988 after the first phase of the Hsiao study had been available. I recall that it was attacked and supported very vigorously. It was only later on that medicine decided to support this.

Chairman STARK. That is right, and not all of them did.

But what I am suggesting is this as an alternative. If we were to say to the physician community that the guillotine drops in 2 years or a year, whatever it takes, and here is the pie, guys; this is all we are going to spend in the aggregate; you fight it out—the surgeons and the optometrists and the pediatricians. You set the relative values, and we will just determine the size of the pie. That is really what we did in the resource-based relative value, is it not?

Mr. GINSBURG. I do not think so. I mean, you had a study that had a lot of participation by the medical profession.

Chairman STARK. Right.

Mr. GINSBURG. But my sense was that the various parts of the medical profession, the various specialties, wanted very much to fight it out in from of the commission and in front of your committee than do it within, you know, some professional branch of medicine.

Chairman STARK. We never had any debate on the relative values.

Mr. GINSBURG. On the specifics.

Chairman STARK. Right.

Mr. GINSBURG. On the specifics, yes.

Chairman STARK. Right. Now why can we not get at least that far on the overhead side, so we do not have to fight. Why should I referee between a proctologist and ophthalmologist when I do not know what they do anyway? Let them worry about it. And what is wrong with that, because we are going to get the same aggregate dollars anyway.

Mr. ANDERSON. Well, unless I am misinterpreting what you are suggesting, Mr. Chairman, I guess the answer would be that there is a principle behind RBRVS. We have adopted that principle for the work values.

Chairman STARK. And who established that principle?

Mr. ANDERSON. I believe Congress established the principle.

Chairman STARK. No, no, no, no. The Hsiao study did.

Mr. GINSBURG. No, the Congress did. There were some major departures from the Hsiao study that were written into the legisla-

tion, and I think Congress made the big decisions. They decided about geographic variation. They decided about—

Chairman STARK. They decided about what?

Mr. GINSBURG. About how to vary the payments in different geographic areas.

Chairman STARK. Yes, yes, yes, yes. Nonetheless we did not get into the issue of whether an office visit was .3 RVOs or an appendectomy was 1.7. That was determined by the Hsiao study, was it not?

Mr. GINSBURG. That is right.

Chairman STARK. All right. I do not think we asked three questions about it. We said: If that is how you want to divvy it up, fine.

Mr. GINSBURG. Mr. Chairman, in leading up to the payment reform, Congress actually did write into the law a series of overvalued procedure reductions.

Chairman STARK. I understand that, and we accepted your testimony, and we will in the future. I am just trying to get back to if it is true that the physicians participated in setting the relative value scale, did they not, and Congress, in the initial practice, was not involved in the Hsiao study.

Mr. GINSBURG. That is right.

Chairman STARK. All right. What would be wrong with demanding that the physician community do the same relative cost or relative resource allocation—you call it whatever you want—and say to them: You all decide, however you choose. You all can review it to make sure they are not gaming the system in some unknown and arcane way. And then we will do it.

What would be wrong with that? Why would we not get to the same place?

Mr. ANDERSON. There is the question about whether public policy objectives will be served on the issue that we were just discussing before, and that has to do with the distribution of physicians, the incentives to expand the generalists and primary care physicians, and the implications of having a reimbursement mechanism that is based upon real input cost to support that broad policy objective.

And I guess my concern might be that if this is limited to professional medicine making decisions about allocations, will the public interest be served?

Chairman STARK. I would presume that the public interest is going to be served by the aggregate amount we spend and that the determination of what overhead is, is a determination of what it is.

Now that is something I can do, and that is something that the IRS can do, and that is something that Touche Ross can do. Overhead is overhead. And if you are paying taxes—and I presume most physicians are—it does not take a rocket scientist, or even an economist, to determine what their overhead is.

This is a factual determination that takes physicians to understand the difference between what a surgeon does and how much office space they need and what kind of supplies they use. To my knowledge, that study has not been done with the participation of the physician community.

Mr. GINSBURG. Mr. Chairman, the reason you cannot use data from the IRS to get this job done is that we are not reimbursing

or passing through overhead expenses of physicians; we are paying them a fee.

Chairman STARK. I understand that.

Mr. GINSBURG. And in a sense so that we need——

Chairman STARK. And half of the fee is determined on some basis in overhead.

Mr. GINSBURG. That is right, but——

Chairman STARK. And now you want to change that, do you not?

Mr. GINSBURG. No. I mean, we still want——

Chairman STARK. Yes, but you want to change how it is divided up.

Now do you want to change it because it is a fair allocation according to the resources used by various specialties, or do you want to use it as a way to change physician behavior?

Mr. GINSBURG. No, the goal is to have it accurately reflect the different resources used——

Chairman STARK. In performing various procedures.

Mr. GINSBURG. In performing various procedures; that is right.

Chairman STARK. All right. Now tell me, either of you, whether you think that a hematologist or a proctologist, in general, would have more resources involved in the procedure that they do most often?

Mr. GINSBURG. Well, we would be going procedure by procedure.

Chairman STARK. Do you have the foggiest idea?

Mr. GINSBURG. We would be going——

Chairman STARK. Paul, I asked you a question. Do you have any idea of what resources a proctologist uses or a hematologist uses?

Mr. GINSBURG. Well, you have to give me the name of a procedure.

Chairman STARK. Do you know what procedures they do?

Mr. GINSBURG. Yes.

Chairman STARK. You do. All right. Well, pick a procedure, and tell me the average, because you have to look at their total practice, not each procedure at a time.

The doctors, at least the ones I have been to say: "We are going to check your blood pressure," and then we are going to give you an electrocardiogram. Go to M and 21st Streets. They do it in one office.

Mr. GINSBURG. That is right. And that is why it is a significant research task to do this, but it is a doable one.

Chairman STARK. Ah!

Mr. GINSBURG. And it has been done.

Chairman STARK. And where was the research done?

Mr. GINSBURG. Basically the way you do it, in our opinion, is, let us take a sigmoidoscopy.

Chairman STARK. How was this research done? How was it done at HCFA?

Mr. GINSBURG. Basically there are two studies that I know about. And basically they talked to physicians or people that——

Chairman STARK. About how many physicians?

Mr. GINSBURG. Well, one study that HCFA is funding covers about 500 physicians. And basically they asked the people that managed those practices: How much time of a nurse does this pro-

cedure take? Does it take a specialized piece of equipment? How much does it cost?

Chairman STARK. Now you are talking.

Mr. GINSBURG. It is data like that, and——

Chairman STARK. Then why can't the doctors, using data like that, come up with something, and that is going to be some negotiating, that they agree on. Why should I have to fight here between the doctors?

We are going to hear testimony today from the guys who are getting gypped or think they are getting gypped because their fees are going down. They are going to groan about what you propose, and those who are going to get a little more money are going to sit here and applaud it.

Why do we want to get into that fight? Why can't you put the doctors in a box and say: OK, guys come up with a solution. We will spend the same amount of dollars either way, because we are going to put the cap on.

So what is wrong with that?

Mr. GINSBURG. Well, I think in either—both in the original approach and in this—what you are being asked to do is just to define an overall method for making these calculations and to choose the numbers here.

Chairman STARK. Well, who is going to choose the numbers?

Mr. GINSBURG. Well, the numbers—as in the fee schedule——

Chairman STARK. Ira Magaziner? [Laughter.]

Mr. GINSBURG. As in the fee schedule, the Congress chooses a method for developing them, and it is the administration's job to come up with 7,000 numbers.

If you recall the Hsiao study, the medical profession wanted to do the study itself.

Chairman STARK. Yes.

Mr. GINSBURG. But HCFA said: No, we want a professor to do this, and you can help him.

Chairman STARK. Yes.

Mr. GINSBURG. And that is——

Chairman STARK. OK. Well, why do we not have you guys do it and let the doctors help you?

Mr. GINSBURG. Well, that is what we have done.

Chairman STARK. Well, I think you are going to hear some testimony today that they do not feel that they were included in those decisions.

Mr. GINSBURG. Well, yes.

Chairman STARK. And all I am saying is, we did it quite well on a much more complicated and less objective target. Professional resources is a very elusive——

Mr. GINSBURG. That is right.

Chairman STARK [continuing]. Sort of thing, the kind of thing they love in the White House. They have about 500 people up there deciding very delicate things like that.

Now we are just talking about numbers such as rent, or stopwatching a nurse.

Mr. GINSBURG. Yes.

Chairman STARK. You learn that——

Mr. GINSBURG. It should be a lot easier to do this.

Chairman STARK. And therefore you should have—if the doctors are in it and there is a deadline, then we do not have all of this complaining.

All I am getting at is, you know, why can't we push that on them and say: You come up with the numbers? We will adjust them anyway; you know that. But at least they are all in. They sign off. Then they have done it.

I do not understand why we have to sort out among the physicians who is winning and who is losing. Why not let them fight over that? What is wrong with that?

Mr. GINSBURG. Well, all you are really being asked to do is just name the approach and then leave it to HCFA or, whoever they choose as a contractor to conduct the research, to involve the doctors.

From the experience that we have had researching this—

Chairman STARK. Then, Paul, where do I get the votes? These guys can dream up consultants; we can go to the Jackson Hole group, but I still have got to pass the bill. Now who do I get to consult with me on that issue?

Mr. GINSBURG. Well, I think the situation now is that you need to produce some budget savings and that—

Chairman STARK. I can do that without any trouble. I think what you are trying to do is a very good idea, but I think politically you have missed the point. You leave it to us to referee the scrapping between the specialties, and that is something that we will do very inefficiently and with a tremendous lack of knowledge, and we could give you some bad results. And then where are we?

All I am suggesting is that it worked—admittedly there was a lot of controversy—but there was never any controversy to speak of in the reimbursement program when we dealt with the relative values. They signed off.

Now what I am saying is, they will stall. If they do not want it, they will not sign off. I can fix that with a deadline, at which point we do not pay them anything. Then, they will agree very quickly.

But then I do not understand what this rush to closure is here.

Mr. GINSBURG. I think the process that you are suggesting is not very different from what the Commission is suggesting. We consider our work to have been in the nature of a pilot study, and we did it to show that it could be done, and—

Chairman STARK. All right.

Mr. GINSBURG. And, maybe we should not have done this.

Chairman STARK. No, that is fine. So then you are saying we need another study to—

Mr. GINSBURG. That is right. It is a pilot study. And the other thing—

Chairman STARK. Then let us suppose we did this. That is one of the issues. We need to study this so we get the right balance. And you have an issue in here: You want to adjust the targets, right? You think that is a good idea?

Mr. GINSBURG. Adjust the targets?

Chairman STARK. For the updates. Right? You think that would be good; is that correct?

Mr. GINSBURG. Yes, I mean, given the need to save money.

Chairman STARK. All right. And then you also want to talk about something—and my question to you on that one, just to put that aside for a moment, is—you intend to make a proposal for supporting graduate medical education. Is there any reason that that would not be just as well determined and legislated in an overall health care reform package, particularly since we do not have the proposal yet?

Mr. ANDERSON. Well, Mr. Chairman, while you were out, we indicated in response to that that reform of graduate medical education could certainly proceed without being tied to broader health care reform proposal because—

Chairman STARK. Or it could be in them.

Mr. GINSBURG [continuing]. Of the long pipeline and the need for changes currently.

Chairman STARK. Let us suppose that we just had a postponement of the update and put the targets in and required that this practice expense phase in take place at some determined point in the future and drop the gavel and said that gets us the \$50 billion. Is there anything wrong with that?

Mr. ANDERSON. If the freeze is on the MEI component of the update, but that the other factors—

Chairman STARK. I was not talking about a freeze. That is a bad word. I am talking about a postponement of the COLA.

Mr. ANDERSON. Well, the postponement of the update—

Chairman STARK. Just like we are going to do to Ginsburg's salary. We are just going to postpone his COLA a little bit.

Mr. ANDERSON. If it only relates to the update factor itself but does not influence some of the other components of the calculation. And I think it would be less objectionable. But there is—

Chairman STARK. OK, but that is what I am saying.

Mr. ANDERSON. I have one concern, Mr. Chairman, and that is that we are running a huge experiment in elements of health care reform in the Medicare program. One of them is a voluntary approach to expenditure targets.

Chairman STARK. Who is running that?

Mr. ANDERSON. Well, I am just saying that the Medicare program has some elements of reform that are envisioned—

Chairman STARK. By whom?

Mr. ANDERSON. I think in your own bill under an approach to a single-payer system with expenditure targets, there are elements of containing increases in expenditures and—

Chairman STARK. That are voluntary?

Mr. ANDERSON [continuing]. The Medicare approach—

Chairman STARK. That are voluntary?

Mr. ANDERSON [continuing]. Is not consistent with your bill, but it is a voluntary approach, and I think we need to understand the implications of having voluntary incentives to contain increases.

Chairman STARK. If I have something in there that is voluntary, let me know, because I will take it out. [Laughter.]

It will not get scored, you know.

Mr. ANDERSON. I am really using that word in a different way.

Chairman STARK. Good.

Mr. ANDERSON. We do not have fixed expenditure targets for doctors.

Chairman STARK. Right.

Mr. ANDERSON. And if their behavior justifies reductions, they occur. If their behavior does not, increases will be—

Chairman STARK. Those are called risks and rewards.

Mr. ANDERSON. Right.

Chairman STARK. OK.

Mr. ANDERSON. And I believe that we need to play that hand out. It would be helpful to understand that approach to expenditure targets.

Chairman STARK. Well, I think we are.

Mr. ANDERSON. Yes.

Chairman STARK. I mean, I have no quarrel with that. I am suggesting that if we do the principal reform that you have mentioned, we are not going to do this practice expense overnight, because it is going to take some more study to get the numbers right. There are other things we can do to hit the target.

The target becomes the balancer. We will just adjust the update and wait because in another month or two we are going to do a reform package, and we can then see how they all mesh together.

Mr. GINSBURG. Mr. Chairman, I think it is a close call to say where the two get savings from, reducing practice expenses components for some services or, say, reducing the update.

What is important is the notion that physicians have a performance standard and they are at risk for how they do. It is really important that just when they did poorly, they were penalized, that if they have earned a reward, that they get a reward, and that—

Chairman STARK. I think that is essential, absolutely essential. And as a matter of fact, postponing the update does that, does it not? It leaves all those risks and rewards in place.

Mr. GINSBURG. Well, yes, if you are saying postponing a component of it, but still have the reward part move through. That is the critical thing.

Mr. ANDERSON. The question is, in my view, if you can begin to move toward the practice expense resource-based approach and achieve the budget objectives at the same time, would that not be preferable, because you are moving toward a long-term—

Chairman STARK. Yes, we could do it. But it just seems to me, it is going to take a little while to negotiate what that is going to be. And as I say, I think we will hear today from other witnesses that there are some differences of opinion. And I would just, you know—that is going to be terribly boring testimony, and it is going to be easy to identify the winners and losers. The winners are for it; the losers are against it. And with the exception of Dr. McDermott, we are not going to understand what they are talking about.

So my instincts are to send them back to the drawing room and say: You guys come up with—in connection with PPRC or whatever you want.

Mr. GINSBURG. I think the physician community clearly has respect for this pilot study, because they are believing the results about who are the winners and who are the losers. I mean, just like they had it in 1988, where—

Chairman STARK. The way to get them to all agree is to make them all losers, big losers, and then they will figure out that maybe

there is a better way. You know, there is a risk and reward in that, too. You have got to want to legislate.

Mr. GINSBURG. Yes. But I do not think that they ever agreed on physician work. The surgeons still do not agree with the concept. It is just that you—

Chairman STARK. Yes, but they bought into it. I mean, the absence was worse. If they did not buy into it, then the threat was they were going to have you coming around and pick procedures and cut the price in half. So we have a deep and abiding appreciation to the incentive you gave them to understand that our legislation was brilliant.

They didn't believe that, but you're worse. You're mean and ugly, you know, tough. So the threat to the physicians to get them to go along is that we don't do what you do. For that, we are eternally grateful.

Mr. McDermott. I apologize.

Mr. McDERMOTT. May I just ask one more question, Mr. Chairman?

Chairman STARK. Certainly.

Mr. McDERMOTT. I wanted to ask about the indirect medical education and your decision to reduce the per resident, per patient or per bed ratio. Do you have some idea in your mind about what the appropriate ratio is, or were you just looking for an amount of money and so you took it down .1 or .2 or whatever?

Mr. GINSBURG. Actually, it is neither. I know that our sister commission ProPAC does research on what the appropriate formula is for the indirect cost, and they have provided advice to you before that they think the formula is too generous.

The only point we were making is that if you have a formula based on residents per bed and you have fewer residents, then automatically the aggregate amount paid out in indirect medical education adjustments is smaller. But we are not proposing any change in that component of the payment system.

Mr. McDERMOTT. In your testimony here, where it says, "While conceived as a possible component of reform, the Medicare elements of the policy would reduce outlays, reductions would come from," you are just saying as a natural result of reducing the number of residents, you would reduce the number of residents per bed?

Mr. GINSBURG. Yes, that's right.

Mr. McDERMOTT. OK. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Just one quick question, because we need to move on. Would it be fair to ask you, would it be within your responsibilities to answer a question for me, to tell me which of the President's part B proposals, and the CBO proposals are the most feasible and those that are least most difficult to carry out, which are best policy and which are worst?

Mr. ANDERSON. We would prefer to think about that as a commission and give you advice later on that. I don't know that I would be able to do that other than in a very arbitrary way at this moment.

Mr. GINSBURG. Mr. Levin, I don't think that any of the proposals that we have reviewed from the administration have serious questions as to whether they could be administered.

Mr. LEVIN. You say you do not have?

Mr. GINSBURG. Yes, I am not aware of doubts that any of them could be administered. The issue was are they good policy or not.

Mr. LEVIN. Right. How about on that?

Mr. GINSBURG. Well, I think we have given you a sense of which ones we support and which ones we do not and which ones we think would be better if they were modified. But I have not discussed ranking them as to which are the best policy. We probably could do that, if you would like.

Mr. ANDERSON. There were a couple of the items that we simply haven't considered and would like an opportunity to do that. For example, bundling the RAP payments will introduce some complex issues in relationships between physicians and hospitals, and we are actually proposing a consideration of an alternative that is consistent with something that we have proposed in our annual report this year, and that is, instead, to take the reductions that we proposed through reform of payments to the anesthesia care team.

Mr. LEVIN. Well, if you could as systematically as possible, as fully as possible within your responsibilities provide us those inputs soon, it would help.

Mr. ANDERSON. We would be glad to do that.

Mr. LEVIN. Thanks.

Chairman STARK. Thank you very much.

Our next panel includes five witnesses representing physician groups. They are Dr. P. John Seward, a member of the board of trustees of the American Medical Association, Dr. Denman Scott, senior vice president for health and public policy with the American College of Physicians, Dr. George Block, chairman of the advisory council for surgery, testifying for the American College of Surgeons, Dr. John Tudor, president of the American Academy of Family Physicians, and Dr. Rufus Stanley, representing the American Academy of Orthopaedic Surgeons.

We welcome the gentlemen to the committee, and seeing that the members of the committee have fought most of your battles for you already, we will ask you to summarize or expand upon your testimony. Your written testimony will appear in the record in its entirety.

We will start off with Dr. Seward.

STATEMENT OF P. JOHN SEWARD, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART, DIRECTOR, DIVISION OF FEDERAL LEGISLATION

Dr. SEWARD. Thank you, Mr. Chairman and members of the committee.

I am John Seward. I am a practicing family physician from Rockford, Ill., and a member of the board of trustees of the American Medical Association, and with me is Bruce Blehart, director of the association's Division of Federal Legislation.

The AMA appreciates the opportunity to appear today before you to discuss the subject of Medicare and Medicaid budget proposals for fiscal year 1994.

As a starting point, we all must recognize that Medicare and Medicaid cuts cannot be viewed in a vacuum. With momentous

changes in how health care services are provided and covered close down the road, the AMA is not treating Medicare and Medicaid budget cuts in the reconciliation process just as business as usual.

The AMA and physicians are cognizant of the need to reduce the budget deficit and to control spending, and we recognize that such decisions are never easy. We suggest that you consider the following principles: Avoid micromanagement; use reconciliation to set directions for reasoned program improvements; maintain the integrity of Medicare's new physician payment system; refrain from actions that could result in an increased regulatory burden; and use caution in program expansion, as new benefits invariably cost more than projected.

From this framework, the AMA has reviewed the President's recommendations and it should probably come as no surprise that the AMA does not support all of the proposed initiatives. However, we do take very seriously the challenge to find potential program modifications that will achieve the required level of savings. While all of the actions we are recommending in our detailed statement have yet to be scored, we estimate that taking these actions would result in savings of over \$3.3 billion in the next fiscal year and over \$19.875 billion over the next 4 years.

Mr. Chairman, as you know, this exercise is not new to the AMA and the others who are before this committee today. What is new, however, is our message and commitment to you that we want to be viewed as and accepted as part of the solution. To a certainty, we will continue to oppose those proposals that will harm our patients and that will splinter the medical profession.

Proposals such as the RAP DRG roll-in and the establishment of Medicaid drug formularies, the evisceration of the RBRVS through arbitrary reductions in the practice component and modifications of the default formula, and setting a single fee for surgical service, regardless of the value provided by an assistant surgeon are clear examples of where medicine is united in opposition to the President's proposals.

But we also recognize our responsibility to aid you in taking actions that will produce the needed savings from or the revenue for the Medicare/Medicaid programs. This is what we mean by telling you and the Nation of our desire for a new partnership.

Having said this, I must tell you that a reading of the statement we submitted yesterday to the committee caused our board of trustees this morning to sit back and reflect once again on the thought of shared sacrifice.

We also recognized that when Congress passed physician payment reform, expectations were created that there would be some predictability in updates. However, we recognize that if budget savings are to be achieved, that it is necessary that individual cuts not single out any particular medical specialty.

To address this and give you an alternative to proposals such as the RAP DRG, single surgical payments and the practice component reductions, we have discussed the possibility of suggesting a 6-month delay in all part B updates, rather than the series of disruptive cuts proposed by the administration.

Such a delay would provide significant 1994 savings and not disrupt the achievements of the RBRVS in physician payment reform.

However, there are consequences in making this suggestion, in light of its impact in many rural and inner-city areas and for some practitioners who are on the margins are making a go.

Yes, while you may find it hard to believe, I can personally tell you that I know physicians who are not covering their practice expenses and are facing still increased regulatory costs. Nevertheless, we estimate that delaying the payment update will result in additional savings of about \$2.1 billion in fiscal year 1994. This is a real and readily achievable saving that does not come at the expense of more Medicare micromanagement or at the expense of our patients. We would be pleased to work with you to see what accommodations can be achieved.

In conclusion, we cannot lose sight of the fact that the Medicare and Medicaid programs provide vital health and medical service to more than 60 million Americans. Because of this reality, we stand firm in saying that substantive changes in the operation of these programs should be made with the context of the needs of beneficiaries, not put together just to meet a budget target.

I would be glad to answer any questions, Mr. Chairman, when it is appropriate.

Thank you.

[The prepared statement follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Re: Medicare and Medicaid - FY 1994 Budget Proposals
Presented by: P. John Seward, MD
March 25, 1993

Mr. Chair and Members of the Committee:

My name is P. John Seward, MD. I am a practicing family physician from Rockford, Illinois and a member of the Board of Trustees of the American Medical Association. With me is Bruce Blehart from the Association's Division of Federal Legislation. The AMA appreciates this opportunity to appear today to discuss the subject of Medicare and Medicaid Budget proposals for FY 1994.

As a starting point, we all must recognize that yet another round of Medicare and Medicaid program cuts cannot be viewed in a vacuum. Your actions this year will be part of a profound series of changes that will alter forever how health and medical care are received in America. As you know, Mr. Chairman, the AMA is proud to be able to say that physicians are leaders in calling for major reform of our health care system. The status quo that has allowed so many of our citizens and patients to have no inadequate or even no coverage for health and medical care simply is unacceptable.

We recognize the need for universal coverage and that attaining this essential goal will not be easy. We support changes that will end discriminatory underwriting in health insurance so that small businesses can afford coverage. We support portability of coverage and real competition in the health benefits market. We believe a partnership can be forged between the medical profession and the government to assure quality of care and budget predictability in a setting of fair negotiations. We support outcomes assessment research and the use of practice parameters to assure the value of medical care.

This is our starting point, and we are pleased to see that movement in this direction is coming and is coming soon. With these momentous changes in the offing and with the real desire to effect positive change in the health care delivery system for all Americans, we urge caution in treating Medicare and Medicaid budget cuts and the reconciliation process as "business-as-usual." While we accept that government programs, including Medicare and Medicaid, must be subjected to cuts in the name of deficit reduction and government belt tightening, it must be recognized that changes made in the government's primary health care programs will send a clear signal as to how physicians, beneficiaries and others can expect to be treated by the federal government in a reformed health care system. Modifications that create further or increased hassles or even appear to be unfair will only make it more difficult to effectuate the kind of change we want for the entire health care system.

Whatever changes are visited upon the Medicare and Medicaid programs through this year's impending budget reconciliation process should have the dual purpose of savings and program improvement. Unfortunately, the blueprint from the past illustrates the difficulty in attaining this goal. The President's recently released series of proposed substantive program modifications is designed to achieve savings. We are concerned that this follows a pattern of huge Medicare reconciliation

packages that have involved literally hundreds of substantive changes over the last decade. These budget driven changes have created substantial turmoil and confusion and the Medicare law is one of the most complex statutes in existence with thousands of pages of seemingly constantly changing instructions and interpretations.

Budget based proposals, such as the Medicare denial of payment for interpretation of most EKGs and arbitrary reductions in physician payments during the first four years of their billing the Medicare program, represent arbitrary actions of highly questionable merit even in terms of potential savings. These provisions did not make good operational sense and, last year, both Houses of Congress voted to repeal them in a budget neutral manner. For this corrective action, we thank the Chairman and this Committee for supporting the necessary legislation. However, this corrective legislation was vetoed for unrelated purposes, and again we are asking for your support to reverse these past legislative actions.

The American Medical Association is cognizant of the need to reduce the budget deficit and to control spending appropriately. Such decisions are never easy. However, the way in which Medicare program cuts are achieved is very important to program operations and the impact on program beneficiaries. With this Committee now facing a reconciliation target of savings that must be achieved, we suggest that you consider the following principles concerning the Medicare and Medicaid programs.

- Micro-management of Medicare is not an effective way to obtain budget savings. Such program changes disrupt the delivery of services and continues the administrative turmoil that has shadowed the program for more than a decade. For example, we do

not believe that the proposal to make a single payment for inpatient radiology, anesthesia and pathology services, as the Administration proposes, should not be adopted. Providing no savings in 1994, the proposal would substantially disrupt the existing relationships between hospitals, patients and this select group of physicians.

- The reconciliation process is not the place to determine, through arbitrary reductions in Medicare payments for direct medical education costs, how to solve physician workforce issues or how to encourage more physicians to train in the primary care fields. Such decisions should be made within the context of a comprehensive overview of the medical education process, not as a budget fix.
- Maintain the integrity of Medicare's new Physician Payment System that is based on a Resource Based Relative Value Schedule (RBRVS). In its second year of a five year transition, it is important to achieve the goals of a sound method of determining physician reimbursement and to encourage the delivery of needed care. Changes that break down the relationship between input and resource costs and reimbursement for services will undo a major accomplishment of establishing a rational basis for determining Medicare reimbursement. This Committee has long been a supporter of the RBRVS. The AMA was also a leader in calling for the development of an RBRVS and worked closely with various Members in seeing the RBRVS go from idea to completion. While there are problems with HCFA's implementation of the program, we still support this methodology.

- Avoid increased program costs by refraining from enactment of increased regulatory burdens. Implementation of the Clinical Laboratory Improvement Amendments of 1988, the OSHA Bloodborne Pathogen Standard, and the Americans with Disabilities Act in just one year have added significantly to the costs of providing medical care. Compliance with CLIA-88 alone is costing individual physicians thousands of dollars per year.
- Program benefits should not be expanded at the same time you are trying to find major savings. New benefits always cost more than projected.
- Comprehensive health system reform should serve as a vehicle for evaluating the role of Medicare in a competitive environment as well as the place for a comprehensive review of physician workforce issues including the best ways of addressing physician specialty issues.

From this framework, the AMA has reviewed the President's recommendations. It should come as no surprise that the AMA will not support all of the President's initiatives. However, we take very seriously the challenge to find potential program modifications that will achieve the desired level of savings. In addition to considering the Administration's budget proposals, we also suggest that the Committee look to items that had been proposed by previous administrations and by others that would reduce costs without disrupting care. For example, bringing state and local government workers, hired before April, 1986, into the Medicare program would raise \$1.2 billion in first year revenues alone. Because most of these workers usually wind up receiving Medicare coverage through a spouse or non-governmental employment, it only makes sense that they pay their fair share during their full working careers.

The following sets out our position on the President's Medicare and Medicaid budget proposals.

While all of the actions we are recommending have yet to be "scored," we estimate that taking these actions would result in savings of over \$3.3 billion in the next fiscal year and over \$19.875 billion over the next four fiscal year period.

MEDICARE PART B

Reduce Physician Fees in 1994 Except Primary Care - This proposal would give the full payment schedule update for primary care services. The update would be reduced by about two percentage points for all other care.

The AMA does not support this proposal. Since 1984, the update for physician services has been substantially reduced by budget driven reconciliation action. Another round of reductions, especially a reduction that differentiates between services, will not be easily accepted by the medical community. While we agree with the intent behind the proposed differential, making primary care a more attractive career path for physicians, we question whether using the annual RBRVS payment adjustment is the best means for effecting such policy. With reimbursement for primary care services scheduled to gain just through the implementation process of the RBRVS and with other services having experienced sometimes substantial take-aways through moving to the RBRVS, we are concerned that a differential update will be unfair. The AMA maintains that RBRVS updates should be consistent and across the board.

Resource-based Practice Expenses Phase-in - This proposal would phase-in a resource-based system for practice expenses under the physician payment schedule beginning in 1997 (a 1993 PPRC suggestion). As an interim step to this phase-in, practice expense RVUs would be reduced in 1994, 1995 and 1996.

The AMA does not support this major reduction in the RBRVS. Rebased practice expenses in this manner, especially during the initial RBRVS phase-in period, would be highly disruptive. While there are anomalies in the practice expense component that need to be addressed, moving to a resource based methodology can be achieved without again extracting huge sums out of the Medicare program. Our concern is that the proposed process to reset the payments for practice expenses would be contrary to the RBRVS by skewing distribution for budget purposes as opposed to setting payments based on accurate data.

Reduce Physician MVPS and Update "Default" Formulas - This proposal would refine the method by which Medicare increases payments to physicians. The proposal would reduce the default formula. The projection for the potential rate of growth also would be lowered.

The AMA does not support setting the assumption for Medicare growth on the rate of growth in the gross domestic product (GDP). Historically, the growth in costs for providing health and medical care has exceeded the GDP, and there is no basis to assume that the Medicare program that provides coverage for the majority of care received by the elderly and disabled populations (those with the greatest need for health and medical care), especially outside of major health system reform, can have its rate of growth slowed to the rate of growth in the GDP.

Bundle Inpatient Radiology, Anesthesia and Pathology (RAP) Payments - Medicare payments for inpatient radiology, anesthesia and pathology would be bundled into a fixed payment per discharge. Payment would be made either to the hospital or the medical staff, and beneficiary coinsurance would be set at 20% of the bundled amount. The proposal states that this approach would give physicians and hospitals incentives

to be cost-conscious, provide only medically necessary services and eliminate the provision of marginal services.

Every time this proposal has surfaced, the AMA has opposed it. The past reasons for opposition are still true, and we continue to oppose this concept. The DRG payment concept for these services would limit physician patient relationships, and would set an inappropriate precedent for bundling physicians' services. The so-called RAP services generally are provided at the request of an ordering physician. While marginal services need to be eliminated, it is very difficult to see how this would occur for the services of an anesthesiologist for a patient undergoing surgery, the services of a pathologist who conducts and interprets a laboratory test, or the services of a radiologist in responding to a STAT request for X-ray or other services. Even if instances could be identified where this care could accurately be described as marginal, savings would be unlikely as the waiver of liability provision probably would apply. Also, this is an example of micro-management that would be contrary to directions taken when the RBRVS was instituted.

Single Fee for Surgery - This proposal would not allow Medicare payment above the level allowed for the primary surgeon for the services of an assistant at surgery. While exceptions would be allowed for "particularly difficult cases," Medicare payments to the primary surgeon would be reduced by the amount of any payments for an assistant at surgery.

The AMA does not support this proposal. It would come on the heels of just implemented 1990 legislation that already severely limits the use of and payment for assistants at surgery, and it simply is contrary to optimal patient care needs. Also, many hospital medical staff bylaws require the use of assistants at surgery as a means of optimizing patient care during particularly hazardous moments in the provision of care, and it is questionable why such a patient care standard should be limited.

Part B Premium at 1995 Percentage of Program Costs with a Limit of 27% of Program

Costs - The Part B Premium is set by law at 25% of program costs. As the budget proposals would lower program costs, the premium should also come down. This proposal would still decrease the dollar amount of the premium while raising funds by setting the premium for 1996 and 1997 at 27%.

Recognizing that the proposal would not result in individuals paying a higher premium in dollar terms, the AMA supports this action that is consistent with the fact that the premium was supposed to cover 50% of program costs when Medicare was instituted. The AMA also believes that consideration and support should be given to a proposal put forth in the previous Administration calling for an increase in the premium rate for individuals with annual income of more than \$100,000 and for couples with annual income of more than \$125,000. This reasonable means testing proposal, as recommended in 1991, was slated to accrue \$313 million in annual revenue, or approximately \$1.25 billion over four years.

Increase Hospital Outpatient Cut - This proposal would extend the current cost reduction of setting these payments at 94.2% of costs to 90% of costs, beginning with services rendered during FY 1996 and thereafter.

While the Association previously has opposed such cuts, we recognize that the still growing volume of services provided in hospital outpatient departments has the potential to offset the proposal. Also, with all elements of the health care spectrum being asked to contribute to the need to lower spending, this seems a reasonable action to maintain the playing field between those who provide care and to address the substantial growth in costs associated with hospital outpatient departments.

Reduce Payment for Clinical Laboratory Services and Provide No Update to

Laboratory Payments through 1998 - The laboratory payment schedule currently is set at 88% of the national median, and it would be reduced to 76%. In addition, no annual update in these payment amounts would be allowed through 1998.

The AMA recommends partial support for the President's proposal, by modifying it so that the payment cap would not be lowered below 80% of the national median. While we would prefer not to see lower payment amounts for these services, it is noted that setting the payment cap based on a median will result in payment for many of these services not being affected. Also, the lower payment amount might have the desirable effect of lowering the volume of questionable laboratory services.

Physician Ownership and Referral - This proposal would extend ownership and referral prohibitions currently applied for clinical laboratory services to additional services such as: physical and occupational therapy; radiology and other diagnostics; radiation therapy; durable medical equipment, parenteral/enteral nutrition equipment and supplies.

The AMA supports this proposal if it is drafted in a manner that is consistent with exceptions for community need as specified in the related report by our Council on Ethical and Judicial Affairs. Where physician investment is the springboard for allowing patient access to previously unavailable care or improved care that will benefit those patients, care must be taken to assure that a blanket prohibition does not jeopardize that care. We hope to work with the Chairman and the Committee in addressing issues such as patient access exceptions, shared laboratories, the divestiture period, and clarifications for group practice situations.

Electronic Billing Incentive - This proposal would create an incentive to encourage submission of Medicare Part B claims via electronic formats by charging \$1 per paper claim beginning January 1, 1996.

The AMA does not support this proposal. While we know that there are positive benefits of moving to electronic billing and taking advantage of other computerization benefits, this should not be achieved through disincentives. Where the proposed penalty would be applied, it is likely to hit hardest those who provide a small volume of Medicare covered primary care services that already are provided at a low fee level. With the development of a uniform claims format and software down the road, it is likely that more and more physicians and others will move to electronic billing, and the proposed savings still will be realized without the penalty being applied.

Durable Medical Equipment (DME) Proposals - DME payments would be reduced by: "tightening" the national payment limits; reclassifying certain items; restoring the carriers ability to adjust payments where the amount is grossly excessive or deficient based on price information; and give carriers flexibility to require demonstration of medical need in advance of delivery of the DME to the patient. The payment schedule for orthotics and prosthetics would be changed to the DME payment schedule. A payment schedule would be established for parenteral and enteral nutrients and supplies, with parenteral and enteral equipment paid on the same basis as DME.

The AMA recommends support for this provision as a reasonable action to address costs associated with the provision of DME.

Set EPO at Non-US Market Rates (\$10 per 1,000) Units - The proposed payment reduction of \$1 per 1,000 units would reduce the disparity between Medicare's current

reimbursement rate and the actual cost that facilities pay for EPO (based on recent findings of the HHS IG.

The AMA recommends having the government purchase the EPO directly from the manufacturer when the intended use is to facilitate treatment of patients with ESRD. Anecdotes from physicians who provide ESRD services tell of situations where the provision of EPO is inadequately reimbursed in some instances. Without limiting the availability of EPO, we believe that possibly an even greater savings can be achieved with an end to hassles facing those physicians treating patients with ESRD by having the government purchase the EPO directly from the manufacturer and in turn supplying the drug to physicians and others.

Extend IRS/SSA/Data Match - This proposal, aimed at enhancing determinations of Medicare secondary payor status, would extend the authorization of the data match through 1998.

Extended Provision Requiring Secondary Payment for Certain Disabled Beneficiaries - This proposal would make permanent the authority setting Medicare as the secondary payor in situations where potentially eligible disabled individuals have other employer based group health care coverage. The current authority is set to end at the end of FY 1995.

Extended Provision Requiring Secondary Payment for Certain Beneficiaries with End Stage Renal Disease (ESRD) - This proposal would make permanent the authority setting Medicare as the secondary payor in situations where potentially eligible individuals receiving ESRD services have other employer based group health care coverage. Secondary status pertains for an 18 month period. The current authority is set to end at the end of FY 1995.

Medicare Secondary Payor Reforms - This proposal would make all of the employer thresholds for determining secondary payor status consistent with the aged provisions (employers of 20 or more). This would lower the disabled eligibility threshold from employers of 100 or more and set a threshold for ESRD patients.

The AMA historically has supported Medicare being a secondary payor where other coverage is available, and we recommend support for these four proposals.

MEDICARE PART A

Phase in a Reduction in the Indirect Medical Education (IME) Payment Adjustment

Ratio - This proposal would alter the IME adjustment formula to reduce these payment amounts beginning in FY 1996.

The AMA recommends support for reducing the IME adjustment to 7%, as also called for by PROPAC, and for a study on how to best finance graduate medical education (GME) to go forward. The AMA historically has supported the IME adjustment as a means of recognizing the added costs incurred by teaching institutions for teaching and as a proxy for uncompensated care. Where initial IME payment amounts were set at a level considerably higher than the added costs of medical education, we have supported reductions to an amount that is adequate to meet the actual, education associated costs that are incurred. To determine the real value and the appropriate IME payment amount, we support conducting a study conducted that will involve physicians, the public, the institutions and others with a stake in medical education.

Reform Payments for the Direct Medical Education (DME) Costs - This proposal

would base payments on a national average per resident amount, with greater weight for primary care.

The AMA supports action to establish uniform accounting for these services, especially in light of the wide variation of cost per resident reported among institutions. With the mean cost for resident services at approximately \$51,000, the reported variation between \$7,500 and \$187,000 must be addressed. By moving to uniform accounting, it is certain that some savings would result. The AMA opposes using a national average in setting the DME payment, as this will underpay in many inner-city areas and overpay in other situations. Also, using a national average overlooks the fact that residency

training costs necessarily must vary by specialty and to account for other factors. Again, we recognize the need for this issue to be subject to scrutiny as the manner in which our nation finances GME is examined.

Eliminate Add-on for Hospital-based Home Health Agencies (HHAs) - This proposal would eliminate the differential, subjecting hospital-based HHAs to the same cost limits as freestanding HHAs.

The AMA questions the wisdom of continuing to pay hospitals more for the provision of HHA services, and we support this proposal.

Eliminate Return on Equity Payments for Proprietary Skilled Nursing Facilities - This proposal would eliminate Medicare ROE payments to proprietary SNFs, to create "fair competition" between SNFs.

The AMA has no position on this proposal.

Extend the 10% Reduction in Hospital Capital Payments - Under current law, hospital capital payments (inpatient Part A and outpatient Part B) are reduced through FY 1995 by 10%. This proposal, consistent with a recent HHS IG report, would make the reduction permanent.

The AMA supports this provision. We note that capital costs have been reduced in this manner pending conversion of capital payments into the prospective payment system as an add on. If this proposal is not adopted, there would be a 10% increase in payment for hospital capital costs.

Hospital Update at Market Basket Minus 1% in FYs 1994 and 1995 - This proposal would set a hospital update amount below the market basket used to set this annual increase.

The AMA historically has called for the hospital update to be made at least at the full market basket amount, and we oppose this proposal. With many hospitals reporting net operating losses, it is particularly difficult to support an update below the market basket amount.

Move the Annual Changes in the PPS Updates to January 1 of Each Year - This proposal would move the PPS update from October 1 to the following January 1.

Recognizing the need to achieve savings, the AMA supports this provision. If a higher level of savings are needed, the AMA also would support a one-time delay in this update to July 1, 1994, with future Part A updates occurring on January 1 thereafter.

MEDICAID

Remove Prohibition on Medicaid Drug Formularies - States now must provide drug coverage for all drugs where they are listed in the medical literature and where the manufacturers have signed rebate agreements. This provision would allow states more flexibility in setting drug coverage.

The AMA continues to oppose arbitrary and budget driven drug formularies as they could be overly restrictive. By eliminating the medical literature requirement, the proposal clearly will limit drug availability, and this will occur to the detriment of patients.

Medicaid Personal Care Services - This proposal corrects a so-called "drafting error" that would have placed a new mandate on state Medicaid programs effective in 1995. Under the proposal, states would maintain the option of paying for personal care services provided outside of a medicaid beneficiary's home.

The AMA has no position on this proposal.

Reduce Medicaid Administrative Match to 50 Percent - This proposal would match all administrative costs at 50 percent.

The AMA recommends that where federal Medicaid law has imposed administrative duties on the states, the initial matching payment should be set at a higher level. However, the administrative match should be phased down to a lower level as higher start-up costs are accrued. States should be allowed the option of petitioning for maintaining higher administrative matches where reductions are considered.

Tighten Estate Recoveries/Transfer of Assets - This proposal would close unspecified loopholes and ensure that those with substantial personal assets pay a fair share for nursing home care and other medical services before Medicaid starts to pay and require recovery from estates of deceased recipients with substantial assets.

The AMA supports the Medicaid program as a health care coverage policy of last resort for those earning below 200% of a state adjusted poverty level. This proposal is consistent with that policy, and we recommend support.

Third Party Liability - This proposal would establish a central clearinghouse to identify third party liability and would ensure that the appropriate insurer paid for care. All

federal health care programs would participate. Employers would be required to verify the existence of health insurance information and initiate payment by the appropriate payor.

The AMA supports this provision as it is consistent with support for the Medicare secondary payor programs. Problems have been identified where physicians and others without adequate information having the responsibility of determining liability, and this proposal could address this concern.

ADDITIONAL MEDICARE AND MEDICAID PROPOSALS

MEDICARE

Duplicate Payment Offset - The Bush Administration proposed this Part A reduction in 1991. This proposal called for the elimination of hospital payments that are offset by the amount of separate payments made to direct billing non-physician practitioners whose services are considered in setting the PPS update. This was projected as saving \$10 million in FY 1992.

The AMA again supports this proposal.

State and Local Employee Coverage Expansion - The Bush Administration made this proposal in 1991 and 1992. This would require state and local government employees hired prior to April 1, 1986 to be included under Medicare. In 1991, this proposal was projected as generating \$1.2 billion in revenues in FY 1992.

The AMA supports taking this initiative. The proposal is consistent with the concept of universal Medicare coverage for all people eligible by reason of age. With most of these workers likely to be

eligible for Medicare by reason of other employment prior to reaching age 65, it does not make sense to allow this special exemption.

Increasing the Age for Eligibility - When the AMA developed its proposal to restructure the Medicare program (in the late 1980's), an element of this proposal was support for an increase in the age used for setting Medicare eligibility. This proposal called for an eight year, phased-in increase in Medicare eligibility to age 67. The proposed rate for this change was set at three months per year.

The rationale for this change remains: it is a fact that the age of eligibility for federally funded health care for the elderly is arbitrary, and changing trends in terms of employment, health status, and longevity of our citizens should be recognized. Since this was proposed initially in the mid-1980's, there has been greater application of the Medicare Secondary Payor program and increasing the age of Medicare eligibility actually is closer to reality.

MEDICAID

Parent Responsibility - States would be required to have noncustodial parents maintain health insurance coverage for their children.

The AMA previously considered this Bush Administration proposal in 1992, and recommended support. This is consistent with many ongoing state initiatives, and it also is good policy.

CONCLUSION

-20-

The Medicare and Medicaid programs provide vital health and medical services to more than 60 million Americans. Substantive changes in program operation should be made in a comprehensive fashion within the context of the needs of the beneficiaries, not put together just to meet a budget reconciliation target. This is especially important as we negotiate our way to national health system reform.

At this time, I will be pleased to answer questions that you may have.

Chairman STARK. Thank you.
Dr. Scott.

STATEMENT OF H. DENMAN SCOTT, M.D., F.A.C.P., SENIOR VICE PRESIDENT FOR HEALTH AND PUBLIC POLICY, AMERICAN COLLEGE OF PHYSICIANS

Dr. SCOTT. Thank you, Mr. Chairman, for the opportunity to present the views of the American College of Physicians. I am Denman Scott, senior vice president for health and public policy.

We support the need for significant long-term deficit reduction. Not only does the economic health of the country depend on it, but as the President has eloquently stated, the prospects for health care reform and the viability of our health care system are integrally bound with deficit reduction.

We appreciate the administration's efforts to protect primary care services. Thus, the administration exempted these services from the proposed 2 percent cut in the 1994 fee schedule update. We will be recommending additional ways to boost primary care medicine, but, at a minimum, we urge the committee to agree to this exemption.

We agree with the proposed reductions in the practice cost relative values for services in which those practice costs are overvalued. That some services are overvalued in the practice cost component reflects a statutory provision that ties this calculation to practice costs figured in the old system as a percentage of historical charges. This favors hospital based and technical procedures, where overhead incurred by the physician is relatively lower.

We have testified previously to this committee and others, and we reiterate today, that a recalculation of practice and malpractice costs to reflect actual overhead is the single most important change this committee can make to assist the primary care practitioner in the short term.

We recognize that in our testimony we have supported some spending reduction proposals, supported others with modifications, and opposed some. Thus, the totals may fall short of the President's goal. We also recognize the pressures for short-term cost control in order to move toward universal access to care and system reform, not to mention the imperative of longer-term cost control.

We believe that other savings are available, both for Federal deficit reduction and systemwide cost control. The most significant area is inappropriate utilization of procedures. We also believe that

there is a problem with overpriced services. Nothing is more insulting to the primary care physician than to work the same long hours as the sub-specialist and come away with reimbursement that is lower by a factor of several hundred percent. It is not so secret, but clearly the profession does not like to talk about it, that too many physicians are drawing incomes in the hundreds of thousands, even over \$1 million, because their procedures are reimbursed so highly.

Let me say a couple of things about primary care. From the point of view of general internal medicine, it is on the ropes. There are many people leaving practice early. The number of people going into primary care is at an all-time low. The Medicare fee schedule, so full of promise, has not really helped the vast majority of internists, according to a recent college survey. There is plenty of money in the physician pot, it just needs some redistribution.

First and foremost, to begin this, I think the practice cost formula, if this is readjusted, will bring some immediate relief. We are beginning, however, to consider among our membership—and this opinion is being more widely held now—that ultimately to affect this redistribution, the fee schedule itself may have to be abandoned and we go to another means of reimbursement of physicians.

Thank you very much.

[The prepared statement follows:]

**STATEMENT OF THE
AMERICAN COLLEGE OF PHYSICIANS
TO THE SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE
March 25, 1993**

Medicare Budget Proposals

Thank you for the opportunity to present the views of internists on the Administration's budget proposals. The American College of Physicians is the nation's largest medical specialty society, with some 80,000 members practicing internal medicine and its subspecialties. I am Dr. H. Denman Scott, Senior Vice President for Health and Public Policy.

We support the need for significant, long-term deficit reduction. Not only does the economic health of the country depend on it but, as the President has eloquently stated, the prospects for health care reform and the viability of our health system are integrally bound with deficit reduction.

Recognizing the difficulties faced by Congress in achieving significant reduction in the deficit, the College does not believe that the aggregate level of proposed reductions in Medicare and Medicaid is overly severe. The reductions total about \$62 billion over a five-year period, out of aggregate spending for that period projected to be well in excess of \$1 trillion. If reductions are taken carefully, in a refined manner, a 5-7 percent cut in projected spending ought to be absorbed without undue hardship. The key question, obviously, is which reductions constitute the right package? Most of this statement will address that question.

We have filtered deficit reduction proposals through two lenses, and hope that this committee will as well. One is the effect on primary care and generalism in medicine (terms that we tend to use interchangeably). The other is the potential effect on health care reform. At this point, most statutory changes will have some effect on the shape of reform, and we want to be sure that spending reductions are consistent with likely longer-term system changes. More positively, this reconciliation package can be used to make changes necessary under any reform scenario, and we urge the committee to view it that way.

Payment Updates

We appreciate the Administration's efforts to protect primary care services (usually defined as office, home, and nursing home visits) in the budget proposals. Thus, the Administration exempted these services from the proposed 2 percent cut in the 1994 fee schedule update. We will be recommending additional ways to boost primary care medicine, but at a minimum we urge the committee to agree to this exemption.

We do not support a change in the default formula for the Medicare Volume Performance Standard (MVPS). We believe that this issue is one of trust in government to hold to agreements reached when the 1989 payment reform legislation was written. When the MVPS targets were exceeded, the payment update was reduced according to the formula. Now that it appears that 1992 spending may come in under the target, and that the update would favor physicians, a change in the formula would be very

poorly received by physicians. While the 1989 legislation is not inviolate, this is one of those issues that speaks to the good faith of the parties and that you, Mr. Chairman, have defended.

Practice Costs

We agree with proposed reductions in practice costs for services in which those practice costs are overvalued. That some services are overvalued in the practice cost relative values reflects a statutory provision that ties this calculation to practice costs figured in the old system -- as a percentage of historical charges. This favors hospital-based and technical procedures -- where overhead incurred by the physician is relatively lower.

Primary care practitioners cannot cover their overhead costs with Medicare payments for many evaluation and management services. Many report that Medicare covers 25-30 percent of overhead, while those costs run as high as 60 percent or greater for many physicians. With doctors under pressure to reduce their exposure to financial loss, the miscalculation of practice costs acts as an incentive to limit the number of Medicare patients in a practice and to perform more office-based procedures.

We have testified previously to this committee and others, and we reiterate today, that a recalculation of practice and malpractice costs to reflect actual overhead is the single most important change this committee can make to assist the primary care practitioner in the short-term. Once again, we urge you to mandate that change in this year's reconciliation bill, for implementation in 1994. A 1997 start date is unacceptable. If Congress makes this change, we believe that PPRC and HCFA, just as they did with the RBRVS system itself, can expedite the development of the necessary data. We need a straightforward instrument that effectively relates the calculation of practice and malpractice relative value units to costs incurred by physicians in their practices. And we need to make sure that the benefit of a statutory change is directed at the generalist physician.

Ban on Physician Self-Referrals

Subject to careful exceptions, we can support extending to other facilities and services the current prohibition on referrals to laboratories outside the practice in which physicians have an investment interest. The exceptions have to do with allowing those referrals where it is clearly in the interest of the patient. The recently revised ACP Ethics Manual provides guidance along the lines that we hope the Committee will recommend: physicians should not refer patients to an outside facility in which they have invested, but an exception should be allowed when capital funding and necessary services are provided that would otherwise not be made available.

Laboratory Fees

We suggest that this is an area where a refined approach, rather than across-the-board reductions, is appropriate. Rather than cutting all reimbursement to 76 percent of the national median, we suggest that the committee identify those laboratory procedures where payments are overpriced and take steps to bring those down. The danger of the across-the-board approach is that payments for specific procedures may be reduced below levels that reflect costs in certain areas, and jeopardize the use of necessary clinical tests. Additional expenditures to comply with the Clinical Laboratory Improvement Act (CLIA) must also be considered.

Payment for EKG Interpretation/New Physicians

Last year, Congress passed a provision restoring payments for interpretation of EKGs and for new physicians, both of which were cut as of January 1, 1992. This was done in a budget neutral manner within the fee schedule. We appreciate the role of this committee in taking this action, and were disappointed that this provision was incorporated in a larger package that was ultimately vetoed by President Bush. We urge you to include this same language in a Reconciliation bill this year.

Graduate Medical Education Financing

Mr. Chairman, while this hearing focuses on Part B, please permit us a brief comment on graduate education support, funded under Part A. We urge you to be very cautious about reductions in the percentage add-on for indirect costs, which is currently 7.7 percent. As you well know, rightly or wrongly this money helps to pay for services to patients without any health coverage. With the uninsured population continuing to rise, severe pressures on state Medicaid budgets, and cuts in county or municipal support for public hospitals, further reductions in Medicare indirect GME payments could worsen access to care unless and until health care reform initiatives provide this funding.

We can support movement towards reducing the very large variation in direct payments for GME support. First, we recommend that this change be implemented on a phased basis, to prevent dislocations to these programs. Second, we suggest that you consider regional averages, rather than a national average, to take into account variations in salary, fringe benefit, and related direct costs. Data on regional and specialty variations in the cost of training must be developed.

We support the idea of giving greater weight to primary care residencies. If this is to make a difference, weightings should be dramatically, rather than incrementally, higher. However, the PPRC has cautioned that this approach may have little impact on the production of primary care physicians unless coupled with restrictions on the numbers of specialty and subspecialty slots. As you know, the weighting factors determine payments to institutions, not physicians-in-training. Stipends vary relatively little among types of residents, and are not likely to be adjusted by differences in Medicare payments. Differences in the revenue potential among services remain much more potent factors influencing the numbers and distribution of residency slots.

We concur with the PPRC's draft paper on physician supply: "...as long as the economic returns to specialization are high and training positions in these fields are available, senior medical students may still be less likely to select careers in primary care." To have substantial effect on primary care, changes in GME funding will have to be coupled with payment and practice environment changes that make primary care careers attractive. We address this question later in our statement.

Achieving Federal Deficit Reduction Goals and System-Wide Short-Term Cost Control

We recognize that in this statement we have supported some spending reduction proposals, supported others with modification, and opposed others. Thus the totals may fall short of the President's goal. We also recognize the pressures for short-term cost control in order to move towards universal access to care and system reform, not to mention the imperative of longer-term cost control. We offer several comments on these points:

Across-the-board proposals have a real potential of driving primary care physicians out of practice. Fee freezes lock in the inequities between primary care and procedures that still exist in Medicare and the private sector. As we stated in the beginning, Congress must use tools that are refined as it approaches the cost control problem.

Without substantial improvements for evaluation and management services, the current RBRVS cannot be applied to other payment systems. Especially at the Medicare conversion factor, the use of the RBRVS-based fee schedule in all payments would be nothing less than devastating to the primary care physician. The College was one of the early and strong supporters of RBRVS. We continue to believe that substantial improvements can make it a viable instrument, but internists have been profoundly disappointed with its effects and would vigorously oppose wider application without positive changes.

We believe that other savings are available, both for federal deficit reduction and system-wide cost control. The most significant area is in the inappropriate utilization of procedures. Without trying to minimize this challenge, it is imperative that the profession, government, and other payers come together on methods to enable physicians to monitor and alter the behavior of their peers. We need to move quickly to redirect current resources for utilization review to a new method of profiling physician practice patterns to identify outliers. Dramatic change often results when physicians are confronted with these data.

There remain procedures that are overpriced, both under the Medicare fee schedule and in the system as a whole. Nothing is more insulting to the primary care physician than to work the same long hours as the subspecialist and come away with reimbursement that is lower by factors of several hundred percent. It is not so secret, but clearly the profession doesn't like to talk about it, that too many physicians are drawing incomes in the hundreds of thousands of dollars, because their procedures are reimbursed too highly, their overhead costs are low, and they are doing procedures of questionable necessity. We hope that the profession can work with the committee to achieve savings in this area.

In most areas of this country, controls on investment in facilities and technology - never strong in the first place, and limited in most areas to inpatient care - were eliminated in the 1980's. In the ACP health care reform paper, we argue that this "capacity" or "supply side" of the system is responsible in part for health care inflation, and that an essential element of cost control will be managing investment. We suggest this area as having substantial potential for achieving the committee's and the President's cost control goals.

If we do a better job of matching the availability of resources to projected need, so that facilities are fully utilized for appropriate services, we can also bring down the unit costs of those facilities. In many areas, those unit costs remain high because they are calculated on underutilization of facilities.

Finally, we suggest that it is time to ask higher income Medicare beneficiaries to pay a larger share of Medicare costs. This would be consistent with the refined approach to spending reduction that we have advocated: that is, to make changes that offer protections where necessary and request more of those who have more.

Revitalizing Primary Care

Mr. Chairman, we urge you to include a "Primary Care Revitalization Act" title in the Reconciliation bill. We believe this would be consistent with, and a necessary precursor to, health care reform. And frankly, this is an issue that can't wait. We hope you will allow us to address it briefly in this testimony.

We are at a crossroads, and as a matter of national policy we have to choose what we want the physician workforce of the future to look like. Should that workforce consist largely of subspecialists, each caring for a disease or organ system using its particular set of technologies or procedures? Or should the workforce have as its core physicians who are generalists, whose comprehensive, continuing care of the patient is supplemented as necessary by subspecialists?

If we do not choose by creating policy, then we will choose by default. Extrapolating current trends, default leads to a workforce of subspecialists, with the primary care or generalist physician playing a role on the periphery, or no role at all.

We urge this committee to begin now to move towards a national policy whose centerpiece is the need for comprehensive, continuing patient care provided by generalist physicians. While we recognize that other Congressional committees must play a role as well, not to mention federal administrative agencies, this committee can take important preliminary steps that may at least reverse the slide and lay the groundwork for long-term policy.

We would like to outline only briefly a number of recommendations:

- Move as quickly as possible to a resource-based calculation of practice costs in the Medicare fee schedule.
- Mandate the use of payment modifiers to reflect the difficulties and additional time involved in caring for patients who are severely ill, over 75, or functionally disabled.
- Authorize payment for managing patients in nursing home or home care settings, which place heavy time demands on physicians for telephone consultations and paperwork, with no compensation at present.
- Consider the advisability of a bonus payment for primary care physicians with "disproportionate" numbers of Medicare patients in their practices.
- Authorize HCFA to protect primary care services in updating relative values in the fee schedule. Medicine is constantly inventing new procedures; at the same time, we do not invent new "visits." Under budget neutral requirements, the proliferation of new procedural codes will shift the balance of total physician work units further toward subspecialty services. We have to find a way to protect the relative values for evaluation and management services from further erosion. HCFA is sympathetic to this problem, but lacks statutory authority to correct it.
- Mandate a major study of the adequacy of our coding and reimbursement systems to describe and pay for primary care. We need to go back to basics, and question our assumptions. Why, for example, do we continue to value procedure time far more than we value evaluation and management time? Why does the generalist have only a few dozen codes to describe his or her patients, while the proceduralist requires thousands of codes, many differentiated by only minute differences? Why does our payment system focus on what is done to the patient, rather than on the treatment of illness? Can we ever expect to capture in a procedurally-oriented coding system the complex web of diagnostic, therapeutic, preventive, and counseling services that the internist may provide in a one-hour encounter with a patient? These and other questions must be asked in developing a payment policy component of a national policy on physician supply that looks at other key factors as well, including factors that can be changed only by the profession itself.

We appreciate your indulgence in allowing us to raise these issues. We look forward to working with you to flesh out these ideas. Without wanting to speak for them or commit them to any specific recommendations, I am sure that you will be able to count on the support of other medical societies who share the goal of revitalizing primary care and have made similar proposals, such as the American Society of Internal Medicine, the American Academy of Family Practitioners, and the American Academy of Pediatrics.

Mr. Chairman, federal deficit reduction and cost control in the health system at large are essential. We ask only that your actions reflect consideration of those areas of the system most in trouble - the providers who deliver primary care and the patients who benefit from that care. Thank you again for this opportunity to share our views with the committee.

Chairman STARK. Thank you.
Dr. Block, I think you are next.

STATEMENT OF GEORGE E. BLOCK, M.D., F.A.C.S., CHAIRMAN, ADVISORY COUNCIL FOR SURGERY, AMERICAN COLLEGE OF SURGEONS

Dr. BLOCK. Thank you.

Mr. Chairman, I am George Block and I am a general surgeon, a fellow of the American College of Surgeons, a member of the faculty at the University of Chicago, and chairman of the advisory council for surgery of the American College of Surgeons.

On behalf of the college and its more than 53,000 fellows, I am pleased to have this opportunity to comment upon some of the Clinton administration's fiscal 1994 budget proposals relating to Medicare.

The administration is asking this committee to approve a provision directing Medicare to pay the same amount for a surgical procedure, irrespective of whether the primary surgeon uses a physician as an assistant at surgery. This is not a new proposal. It is the same bad idea that was recommended to you by the Bush administration 3 years ago and was appropriately rejected by this committee.

The college opposes this proposal, because it is inconsistent with the concept that Medicare should pay for the physician's services that are required by the Medicare patients. The decision to use an assistant at surgery should depend upon the complexity and difficulty of the procedure and the condition of the patient. The primary surgeon has the obligation to determine the need for an assistant at surgery.

While Medicare has a legitimate interest in evaluating the appropriateness of the use of assistants at surgery, the program also has the responsibility for paying for the needed professional services that Medicare patients require. Medicare payments for assistants at surgery totaled less than 1 percent of all allowed charges for part B in 1990.

This rather outrageous proposal introduces unwarranted economic pressures on what should be medical decisions about the safety needs of patients who require operations. The proposal is inappropriate and, again, should be rejected.

The administration is also proposing what they call an "interim step" toward a resource based system for practice expenses in the Medicare fee schedule. A more comprehensive system would be phased in by 1997. We have steadfastly opposed the resource based approach, because it is a method that focused on efforts and not re-

sults. It is a system that sets values for service, regardless of outcomes or quality.

The college fears that extending the so-called resource based method to practice expenses would cause further massive reductions in fees for many surgical and other services, without any assessment of the implications for Medicare patients or their physicians. We are particularly concerned about the potential devastating impact that such a scheme would have on small surgical practices, especially in many rural areas, where continued access to general surgeons and other surgical specialists is essential in order to maintain their fragile health care systems.

The administration has proposed also modifications of certain features of the Medicare volume performance standards. The American College of Surgeons remains a very strong proponent of performance based approaches. The college is convinced that volume performance standards, including a separate identifiable standard for surgical services, are a very effective means of focusing the physicians on the utilization of their services. The surgical community has been successful in meeting the surgical MVPS goals for both 1992 and 1993.

Because of our limited experience with this new expenditure target tool, we urge caution in the adoption of any major changes in the design of the MVPS. Nevertheless, we would urge two considerations: First, the college supports a modification of the definition of surgical services to include all surgical services, including evaluation and management services. This would remove the sources from the nonsurgical expenditure target and charge them, instead, against the surgical MVPS. Second, the college supports amending the current system to establish a separate MVPS for primary care services. This change would allow policymakers to consider volume issues relating to justifiable increases in these services.

The college remains unalterably opposed to the establishment of State level volume performance standards, for fear that this would introduce political pressures into the annual allocation of resources into what is a national program for the elderly.

Finally, the administration proposes a full fee schedule update for calendar 1994 for primary care services only. Why the continued discrimination? Medicare has adopted a fee schedule that was supposed to redress these alleged imbalances in relative values.

The college appreciates the opportunity to comment on the Clinton administration's budget proposals. Mr. Chairman, I would be pleased to respond to any questions you or the subcommittee members may have.

[The prepared statement follows:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS
to the
U. S. House of Representatives
Committee on Ways and Means
Subcommittee on Health
presented by
George E. Block, MD, FACS
RE: President Clinton's FY 1994 Budget Proposals
March 25, 1993

Mr. Chairman and members of the subcommittee, I am George E. Block, MD, FACS. I am a general surgeon, a member of the faculty at the University of Chicago, and chairman of the Advisory Council for Surgery of the American College of Surgeons. On behalf of the College and its more than 53,000 Fellows, I am pleased to have this opportunity to comment on some of the Clinton Administration's fiscal year 1994 budget proposals relating to the Medicare program.

Single Fee for Surgical Procedures. The Administration is asking this committee to approve a provision directing Medicare to pay the same amount for a surgical procedure regardless of whether the primary surgeon uses a physician as an assistant at surgery. Under the proposal, Medicare would reduce payment for the primary surgeon by the amount of any separate payment for the assistant. Of course, as you know Mr. Chairman, this is not a new proposal. It is the same bad idea that was recommended to you by the Bush Administration three years ago--and rejected by this committee. The College is just as strongly opposed to this proposal now as then, because it is still fundamentally inconsistent with the concept that Medicare should pay for physicians' services that are required by Medicare patients.

In 1990, in lieu of the single fee plan, Congress adopted two provisions relating to assistants at surgery under Medicare. One of these provisions eliminated any payments for assistants when program claims data indicated that they were used for an operation less than 5 percent of the time. This provision assumes that if an assistant is used infrequently for an operation, then an assistant must not be necessary. However, the fact that a service may be required by less than 5 percent of the Medicare population has no bearing on the needs of a particular patient. Therefore, we still believe that the program should pay for medically necessary assistants at surgery, no matter how frequently or infrequently they are required for any operation. However, we have worked with the Health Care Financing Administration (HCFA) to implement this unfortunate provision in the least disruptive way possible.

A second provision reduced the payment amount for an assistant at surgery from 20 to 16 percent of the primary surgeon's global fee. The College was very concerned about the effects of this provision on the availability of assistants, especially in areas where such assistants must travel long distances. In its 1992 report to Congress, the Physician Payment Review Commission (PPRC) noted that the 16 percent rate was lower than the resource costs involved for many operations. The Commissioners also warned that "when combined with reductions in payments for surgical procedures, the 16 percent rule may make it difficult for surgeons to recruit assistants." Unfortunately, many surgeons across the country are reporting that, in fact, it is becoming increasingly difficult to secure assistants at surgery.

Mr. Chairman, the decision to use an assistant at surgery depends on the complexity and difficulty of the procedure, as well as the condition of the patient. Some operations, such as laparoscopic cholecystectomies, require four hands. Other operations rarely require an assistant. The health status of the patient also is a critical factor, and the primary surgeon may determine that using an assistant at surgery will reduce the risk of mortality or morbidity. Reducing operative time is especially important in minimizing the risks for those older Medicare patients who are in poor overall health.

While Medicare has a legitimate interest in evaluating the appropriateness of the use of assistants at surgery, the program also has the responsibility for paying for the needed professional services that Medicare patients require. In addition, we believe it is important to point out that, in 1990, Medicare payments for assistants at surgery equaled less than one percent of the total allowed charges for Medicare Part B for that year, based on BMAD data that were provided to us by HCFA. This budget proposal only introduces unwarranted

economic pressures on what should be medical decisions about the safety needs of the patients who require operations. The proposal is inappropriate and again should be rejected.

Resource-Based Practice Expenses. The Administration is proposing what they call an "interim" step toward a resource-based system for practice expenses in the Medicare fee schedule. A more comprehensive phase-in to a resource-based system would start in 1997. The College has been, and remains, opposed to using this so-called resource-based methodology for practice expenses under the Medicare fee schedule. We have steadfastly opposed the resource-based approach, because it is a method that focuses on efforts, not results. It is a system that sets values for services regardless of outcomes or quality. We see no reason to expand the use of such a methodology to the practice expense component of the Medicare fee schedule.

As you know, a very extensive redistribution of physician payments under Medicare occurred after the implementation of the so-called resource-based relative value scale, and the effects of these changes are neither complete nor fully evaluated. The College fears that extending the so-called resource-based method to practice expenses would cause further massive reductions in fees for many surgical and other services, without any assessment of the implications such changes may have for Medicare patients or their physicians. We are particularly concerned about the potentially devastating impact that such a scheme most assuredly would have on small surgical practices throughout much of the country, and especially in many rural areas where continued access to surgical and other services would be threatened. We believe that access to surgical care is as important as access to primary care services in rural areas. Moreover, for many primary care physicians and hospitals, access to surgical specialists is essential in order to maintain the fragile health care systems in rural areas.

It also should be clear from the advice provided to you by the PPRC that the information base to evaluate or implement this kind of major payment change--even if the expected effects on your constituents were known--does not exist. In our judgment, payment changes of the kind envisioned in the proposal should not be approved even on an "interim" basis until at least some basic questions about this plan are answered and understood.

Medicare Volume Performance Standards. The Administration has proposed modifications in certain features of current law that pertain to the Medicare volume performance standards (MVPSs). As you well know, Mr. Chairman, the American College of Surgeons was, and remains, a very strong proponent of performance-based approaches to address the concerns of policymakers about the volume and intensity of services provided under the Medicare program. In fact, we do not believe that physician payment reform could have been approved unless it was accompanied by some mechanism resembling the MVPSs.

The College is convinced that volume performance standards, including a separate, identifiable standard for surgical services, are a very effective means of focusing the attention of the physician community on the utilization of their services. Obviously, we have been very pleased that the surgical community was successful in meeting the surgical MVPS goal for the 1993 update. The challenge now is to make the MVPS concept work for all of medicine.

Despite our support for the MVPSs, we recognize that we have had very limited experience with this new expenditure target tool. For this reason, we have urged caution in the development of any major changes in the design of the MVPSs, such as structuring the standards on something less than a nationwide basis or covering unduly narrow categories of services. But, based on what we have learned thus far, we urge you to consider two important changes in the measurement of performance under the MVPS for surgical services that will strengthen its effects.

First, the College supports a modification of the definition of surgical services for the purposes of setting the surgical target to include all services performed by surgeons, not just their procedural services. By making this change, for example, expenditures for surgeons' separately identifiable evaluation and management services would be removed from the nonsurgical expenditure target and charged against the surgical MVPS.

Second, the College supports amending the current system to establish a separate MVPS and fee schedule update for primary care services. This change would allow policymakers to consider volume issues relating to justifiable increases in the number of primary care visits under its own separate performance standard, at least until definitive medical necessity criteria, practice guidelines, and/or a workable system of physician profiling can be developed to judge the appropriate utilization of those services.

The College remains unalterably opposed to the establishment of state-level volume performance standards, because we believe that such an approach only will introduce major political pressures over the annual allocation of resources for physicians' services under what is essentially a national program for the elderly. It is a well-known fact that many patients are referred to, or otherwise obtain the services of, physicians (particularly specialists) from outside of their own communities and states. Political boundaries should not distort reasonable attempts to establish expenditure targets for physicians' services.

Because we do not have the specific details of the proposals from the Administration relating to potential reductions in the MVPSs, we are not able to make a full assessment of these recommendations. But, as a matter of policy, the College is very concerned about any changes that tend to erode the underlying performance-based concepts inherent in the MVPSs. Obviously, for example, if future performance standards are set for Medicare without any real concern about the expected effects of factors that actually determine the expected rate of growth in physician expenditures, then the ability of surgeons and other physicians to meet such standards will be compromised. We also are concerned about possible changes that might make the "default" formulas more attractive than the explicit setting of targets and updates after careful consideration of all the issues involved, not just budget goals alone.

1994 Fee Schedule Updates. The Administration proposes a full fee schedule update for calendar year 1994 for primary care services only. For other physicians' services, the update would be two percentage points below the full update. We are completely opposed to this proposal. Why the continued discrimination? Medicare now has adopted a fee schedule that was supposed to redress the alleged imbalances in the relative values for various categories of physicians' services. In addition, at least insofar as surgical services are concerned, surgeons have met much more restrictive Medicare volume performance standards than have been applied to other physicians' services. The College believes that differential updates in fees should be based only on performance. If Congress feels obliged to reduce payment updates as part of a broad budgetary reduction plan, then these reductions should be made equally for all services covered by the program--that is, a truly "shared sacrifice" among all physicians.

Again, the College is pleased to have this opportunity to comment on the Clinton Administration's budget proposals. Mr. Chairman, I would be pleased to respond to any questions you or the subcommittee members may have.

Chairman STARK. Thank you very much.
Dr. Tudor, you are next.

**STATEMENT OF JOHN M. TUDOR, JR., M.D., PRESIDENT,
AMERICAN ACADEMY OF FAMILY PHYSICIANS**

Dr. TUDOR. My name is John M. Tudor, Jr., M.D. I am a family physician in private practice in Salt Lake City. I serve as the president of the American Academy of Family Physicians.

I appreciate this opportunity to comment on the Medicare provisions in the proposed fiscal year 1994 budget. The larger context in which the new administration has proposed its budget challenges us to adopt a new perspective. Proposed budget cuts and tax increases must be considered as part of the President's strategy to revitalize the American economy. The Medicare budget cuts also must be considered in the context of the administration's efforts to reform the American health care system.

The President's strategy for economic revitalization includes as package of investments designed to bolster the economic infrastructure. Another essential aspect is reforming the health care system. The President clearly understands the success of health care system reform rests on a substantial increase in the availability of primary care services.

Many of our current health care problems can be directly attributed to decades of neglect suffered by this country's primary care infrastructure. This neglect can no longer be sustained, if every American is to be assured access to appropriate health care, and if health care costs are no longer to constitute an ever-growing drain on the American economy.

Primary care physicians are the infrastructure of America's health care system. My message today is a simple one: As you consider the difficult choices presented in the budget proposal, you must bear in mind that rebuilding of the primary health care system is an essential investment in America's economic future.

We are encouraged that several provisions within this budget appear to exempt primary care services from budget cuts and/or to orient existing financial incentives toward primary care. Because the Medicare proposals are not sufficiently detailed, the following comments should be regarded as preliminary.

The Academy applauds the proposed reweighting of direct graduate medical education payments. However, we believe that a much more radical reform will be necessary in order to correct the severe over-specialization of the physician supply.

GME must be unleashed from its exclusive link to inpatient facilities. Ambulatory training facilities should be eligible for both direct and indirect medical education payments. As long as the overwhelming majority of GME dollars flow to hospitals, there is little reason to expect any significant change in graduate medical education training. Furthermore, the proposed reductions in the indirect GME rate may adversely affect family practice residency programs, which are those that are least likely to bring in substantial revenue.

We believe the exemption of primary care services from proposed reductions in the 1994 fee update to be consistent with the administration's policy of promoting primary care. On the other hand, we

are concerned that the proposal to lower the floor in the Medicare volume performance standard default formula will have an unintended and perverse impact on primary care services.

The current use of surgical and nonsurgical volume performance standards inappropriately groups visit services with diagnostic and treatment procedures, like imaging and endoscopy, which have grown rapidly. We believe that an additional category of physician services should be established for visits. The creation of a visit category will protect primary care services from a recurrence of the unjustifiably low update received in 1993. Furthermore, delays in implementing these updates will perpetuate the inequities of the existing fee schedule.

The Academy strongly supports PPRC's resource based practice expense payment method. Paying average practice expenditures, as is specified in current law, penalizes primary care offices where the overhead is above 50 percent. It is important to note that PPRC's proposal calls for budget neutral implementation, whereby, the payment for overvalued services would decrease, while payments for undervalued services would simultaneously increase.

We are concerned that the administration's proposal to reduce overpayments would divert for deficit reduction purposes funds that would never be used to increase the undervalued practice expenses. We urge the subcommittee to consider carefully the perverse longrun impact that this provision would have on establishing a resource based practice expense component.

Finally, we believe that the proposed reduction in payments for clinical office laboratory services is unjustified, because of the increased costs of providing lab services in clinical practice.

It has been my privilege to address these important issues. Please accept my sincere offer to assist the committee in any way possible in its deliberations related to Medicare budget and larger issues of health care reform.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JOHN M. TUDOR, JR., M.D.
President
American Academy of Family Physicians

I am John M. Tudor, Jr., M.D., and it is my privilege to serve as President of the American Academy of Family Physicians. On behalf of the Academy's 74,000 members, I wish to express our appreciation for this opportunity to appear before the Subcommittee and to comment on the Medicare provisions in President Clinton's proposed budget for Fiscal Year 1994.

The larger context in which the Administration has proposed its FY94 budget challenges us to consider this budget from a new perspective. This is particularly true in regard to the Medicare provisions. In general, the budget must be considered as part of the President's three-pronged strategy to revitalize the American economy. The Medicare budget, in particular, must be considered in the context of the Administration's efforts to reform the American health care system. We recognize that a simple arithmetic assessment of how the proposed Medicare cuts will impact on the financial well-being of family physicians fails to do justice to the fuller implications of this proposed budget.

In formulating our response to this year's budget proposal we have taken our lead directly from the President, who has asked for a shared sacrifice to achieve the combined goals of deficit reduction, short-term economic stimulus, and long-term investment in the economic infrastructure. We choose to view the Medicare provisions as part of a wide-ranging set of spending cuts and tax increases designed to ensure that no one sector of the economy is unfairly singled-out. We do not believe that health care or health care providers possess a special status that should automatically result in an exemption from this nation's collective responsibility to ensure its future economic health.

Having said this, I hasten to raise the Academy's long-held concern about unjustifiably low Medicare payments for primary care services. Our estimates suggest that Medicare fees for office visits, which are the services most frequently provided by family physicians, are often below cost. The extent to which the budget proposal might push fees further behind costs only serves to exacerbate the problem. Our concern is moderated to a degree by the role that the proposed Medicare cuts may play in the larger health system reform effort. We will reassess our position on the proposed Medicare budget after the Administration's health system reform proposal is unveiled.

As noted earlier, the President's three-pronged strategy for revitalizing the American economy includes a package of investments designed to bolster the infrastructure for long-term economic growth. Another essential aspect of the President's economic revitalization program is reforming the American health care system by bringing health care costs under control and ensuring universal access to appropriate health care services. The President has repeatedly demonstrated his clear understanding that the success of health system reform rests on a substantial upgrading of the availability of primary care services. Indeed, many of the current problems in the American health care system can be directly attributed to the decades of neglect suffered by this country's primary care infrastructure. This neglect can no longer be sustained if every American is to be assured access to appropriate health care and if health care costs are no longer to constitute an ever-widening drain on the American economy. My message today is a simple one. As you consider the difficult choices presented in the Administration's budget proposal, you must recognize, as the President has recognized, that rebuilding of the primary health care system is an essential investment in the economic infrastructure of this country.

The Clinton Administration has adopted an approach to reducing the federal budget deficit that is noteworthy in two important aspects. First, the Administration has avoided the temptation to limit its FY94 proposal to budget cuts and has, instead, included well-targeted investments in the economic infrastructure. A meaningful reduction in the deficit can probably only be

achieved through a combination of budget cuts and economic growth. We believe the long-term investments proposed in the President's budget can provide a foundation for economic growth that might not otherwise occur.

Second, the Administration has expressed a clear intention to tailor its proposed cuts in the Medicare budget to be consistent with its vision for health system reform. In this regard the Administration has clearly recognized that controlling health care costs and achieving universal access will require a substantial upgrading of the primary care infrastructure. Specifically, this will require a substantial change in the specialty and geographic distribution of physicians. From the current ratio of 70 percent specialists to 30 percent generalists must be achieved an equal distribution between specialists and generalists. Furthermore, the geographic distribution of physicians must more closely approximate that of the general population.

Consistent with this recognition, the Administration's proposed budget includes several provisions that appear to either exempt primary care services from budget cuts or reorient existing financial incentives to encourage the greater availability of primary care services. The level of detail regarding the Medicare provisions in the proposed budget is not sufficient to fully assess their eventual impact. The following comments on a few specific provisions should be regarded as preliminary until such time as more detailed proposals are available from the Administration.

Graduate Medical Education Payments - The analytic basis for reducing indirect medical education payments stems from several well-publicized analyses suggesting that the current indirect rate exceeds the added patient-care costs associated with medical education. The proposal for reforming and rationalizing direct medical education payments would standardize the per-resident amount based on the average annual resident salary, weight direct payments substantially in favor of residents in the generalist specialties, and reduce DME payments by setting weights below a budget-neutral level.

We are concerned that the proposed reductions in the IME payment rate may have a perverse impact on generalist residencies. Faced with a reduction in IME payments, hospitals are likely to target cut backs on those residency programs that bring in the least revenue, which tend to be in the generalist specialties.

The proposed reweighting of direct payments would set an important precedent and is entirely consistent with the direction of health system reform. However, the Academy believes that a much more radical reform in GME payments will be necessary to correct the severe specialty and geographic maldistribution. Despite the fact that medical care is increasingly ambulatory in nature, Medicare GME payments are funneled exclusively through hospitals and tend to more richly reward programs training the procedural and surgical subspecialties. The Academy believes that Medicare GME must be unleashed from its exclusive link to inpatient facilities. Ambulatory training facilities should be eligible for both direct and indirect medical education payments. These changes can be accomplished in a budget-neutral manner. However, the proposed reduction in GME payments will make the necessary changes in GME funding more difficult to achieve. As long as the overwhelming majority of Medicare GME dollars flows to hospitals there is little reason to expect any significant change in graduate medical training.

Physician Fee Update - The Academy believes the exemption of primary care services from the proposed reductions in the 1994 fee update to be consistent with the intent of the Medicare fee schedule and with the policy of promoting primary care. It is our understanding that a moderation in the growth in the volume of Medicare physician services in 1992 will result in a higher update in 1994 than has

occurred in recent years. We are concerned that the proposed reduction in the update will violate an agreement established with Medicare physician payment reform. As noted above, our concern is moderated to the degree that the proposed reduction may be linked to the larger health system reform effort.

Medicare Volume Performance Standard - The Academy is concerned that the proposal to lower the floor in the MVPS default formula will have an unintended and perverse impact on primary care services. The current crude categorization of physician services into surgical and non-surgical groups places visit services, which are those most often provided by family physicians and which have experienced only moderate volume growth, with diagnostic and treatment procedures, which have undergone the most rapid growth in volume. For the purposes of the MVPS, we believe an additional category of physician services should be established for visits. The creation of an additional visit category will protect primary care services from a recurrence of the unjustifiably low update received for 1993.

Resource-based Practice Expense Phase-in - The Academy has long supported the resource-based practice expense payment method developed by the Physician Payment Review Commission, which would correct an egregious inequity in practice cost reimbursement. The current method of calculating practice expense payments relies on historic costs and incorporates traditional inequities that physician payment reform was intended to correct. Inadequate Medicare practice expense payments for office-based visit services has had a chilling effect on the willingness of family physicians to take on new Medicare patients.

While we appreciate the Administration's tacit support of the PPRC proposal, it is important to note that PPRC called for a budget-neutral implementation, whereby payments for overvalued services would gradually decrease while simultaneously increasing payments for those practice expenses that are currently undervalued. The Administration's proposal would establish an interim step toward a resource-based method by immediately reducing practice expense payments that are deemed to be overvalued but delaying any increase in payments for undervalued services. We are concerned that this asymmetric phase-in will undermine the intent of the PPRC proposal by eliminating the funds available for eventually increasing payments for currently undervalued practice expenses. We urge the Subcommittee to carefully consider the perverse long-run impact that this provision would have on establishing a resource-based practice expense component to the Medicare physician fee schedule.

Payments for Clinical Laboratory Services - We believe the proposal to reduce payment for clinical office laboratory services to be unjustified in view of the onerous administrative burden imposed on physician office laboratories by the regulations implementing the Clinical Laboratories Improvement Act of 1988. In our opinion the CLIA regulations fail to faithfully implement the intent of the act, bear no demonstrable relationship to quality, have substantially increased monetary and non-monetary costs for both patients and physicians, and have had a negative impact on access to appropriate laboratory services. The proposal to reduce payments for laboratory services will further exacerbate access problems. We will examine the Administration's health system reform proposal for evidence of outcome-based regulations that will supplant the unjustified and overly burdensome process-based regulations epitomized by CLIA-88.

It has been my privilege to address these important issues today. On behalf of the Academy, please accept my sincere offer to assist the Committee in any way possible in its deliberations related to the Medicare budget and the larger issue of health system reform.

Chairman STARK. Thank you, doctor.
Dr. Stanley.

**STATEMENT OF RUFUS F. STANLEY, JR., M.D., CHAIRMAN,
COMMITTEE ON HEALTH CARE FINANCING, AMERICAN
ACADEMY OF ORTHOPAEDIC SURGEONS**

Dr. STANLEY. Mr. Chairman and members of the subcommittee, thank you very much for letting us be here.

My name is Rufus Stanley, and I am a practicing orthopedist in Houston. I am here today on behalf of the American Academy of Orthopaedic Surgeons, whose membership includes almost all of the board-certified orthopedic surgeons in this country. The committee has our prepared testimony and I will summarize.

Our academy is heavily involved in developing and promulgating cost reduction measures for the delivery of musculoskeletal care. We know the problem and we intend to help. We would like to share with you today a summary of our thoughts about practice costs, assistants at surgery and ownership referral.

Mr. Chairman, I cannot overemphasize to you our concern regarding the administration's supposed desire precipitously to enact, through accounting devices, steep reductions in the practice cost factor of the resource based relative value scale for Medicare.

Perhaps the degree of our concern is illustrated in part by a meeting we are hosting today in this city of representatives of about 15 medical societies to better understand the intricacies of these proposed reductions and their potential impact on the care of the Medicare patient.

As we have expressed to the Physician Payment Review Commission, we have serious reservations regarding whether the methodologies used to recalculate practice costs are, indeed, capturing the cost of doing business, especially in the so-called procedural areas and in the small group and in the rural practices.

We ardently agree with the PPRC in their recent recommendation that more data be gathered and analyzed further, before such drastic reductions be implemented. We believe strongly in maintaining practice efficiently and recognizing, and indeed inventing sources of overhead reduction in medicine and surgery.

But, Mr. Chairman, in order to provide our Medicare patients with continuing access to musculoskeletal care, we have to keep the doors open. Don't convert practice costs to a resource base and don't arbitrarily impose large reductions for budget reasons until we know what the numbers are and what their impact will be.

On another issue: viewed from the perspective of providing our Medicare patients with the most cost-effective care available in the system, deleting specific payment for surgical assistants across the board in our mind is wrong-minded.

In orthopedics, as in all other areas of surgery, incentives should be directed toward provision of the most fully trained and qualified assistants obtainable, be it for stabilization, for example, of a fractured spine to prevent paralysis, the removal of a large and threatening bone tumor or whatever.

While a glimmer of consolation perhaps could be realized from the proposed policy exemption of "particularly difficult cases," we

have learned from experience, frankly, that it can be particularly difficult to agree with payers about what is particularly difficult.

So, Mr. Chairman, deleting assistants payment further penalizes—actually by about 16 percent—the performance of difficult work in procedures posing more risk to the Medicare patient. Resource based philosophy, and indeed we think common sense, dictate that more difficult and intricate activity be rewarded and not penalized.

Finally, Mr. Chairman, we agree with you wholeheartedly that “turning a physician’s decision to refer a patient into a marketable commodity” is bad medicine, within or without the context of cost control.

Further, we thank you for using the very good judgment of continuing in H.R. 345 the exemption of so-called in-house services such as office x ray. In orthopedics, as we believe you very well know, an x ray check, for example, is an integral part of proper fracture treatment.

Thank you again for letting us be here. I would be happy to try to answer questions.

[The prepared statement follows:]

TESTIMONY OF RUFUS F. STANLEY, JR., M.D.
American Academy of Orthopaedic Surgeons

Mr. Chairman and members of the subcommittee, I am Rufus F. Stanley, Jr., a board-certified practicing orthopaedist from Houston, Texas and past chairman of the Committee on Health Care Financing of the American Academy of Orthopaedic Surgeons.

On behalf of the 14,000 fellows of the Academy, thank you for the opportunity to present testimony on the Medicare Part B Budget Proposal. Let me begin by stating that we appreciate the tremendous pressure that you, and the new Administration, are under to get a handle on federal spending. It is a concern that all of us must share.

We would respectfully submit to you, however, that even though we cannot afford this mounting Federal deficit, we also cannot afford to reduce it with the arbitrarily, hastily conceived health care approaches proposed by the Office of Management and Budget. Our first priority must always be to act in the best interest of the patient.

During the last few months health care professionals have expected from the Clinton Administration a comprehensive, innovative approach to health care reform. Instead, this budget proposal represents the same old budgetary cuts which we have seen in the past.

The Congress should not attempt to micro-manage the Medicare program, and should not constantly change the rules of the game, continually "pulling the rug" out from under certain health care professionals. These constant disruptions, changes, and tinkering with the Medicare program have only served to disrupt the delivery of health care services, and to adversely affect the quality of care.

Transition to the new Medicare payment system began only fourteen months ago, representing the most dramatic change in the way physicians are reimbursed in the history of the program. Member of this subcommittee will recall the monumental effort undertaken by the medical profession and the federal government to develop this new payment system. Medicare volume performance standards and, especially, the Medicare fee schedule took years to develop. The fee schedule is still in a delicate transitional phase. We believe the Administration's budget proposal, if implemented, would undermine the goals of Medicare payment reform. It would also place an undue burden on surgeons in caring for Medicare patients.

In our testimony, we wish to discuss the following issues:

1. Calculating the RBRVS Practice Expense Component
2. Single Fee for Surgery
3. Physician Ownership and Referral

Calculating the RBRVS Practice Expense Component

We cannot over-emphasize our concern about the proposal to change the calculation of the RBRVS practice expense component. This issue is so important that while this hearing is taking place today, representatives of several surgical specialties are meeting, at a gathering sponsored by the American Academy of Orthopaedic Surgeons in Washington, D.C., to more fully study the adverse implications of this proposal.

We strongly urge that the current method for calculating practice expenses under the RBRVS be maintained until a resource-based approach, with adequate support data, has been developed. We believe that the Physician Payment Review Commission approach being considered is only under development at this time and contains many unresolved issues. By the PPRC's own admission, it should not be phased-in beginning next year.

We have the following concerns about the methodology:

- One, that the methodology, which attempts to allocate cost between direct and indirect categories, may not compensate the surgeon for the reasonable practice expenses that are incurred in treating Medicare patients. We are particularly concerned about the individual who is in solo practice or is part of a small group practice. We are concerned that neither of these practice models may have a sufficient patient population to experience the "right" case mix to fully recover practice expenses.
- Two, we are concerned about the assumption that "most direct costs are only incurred for services provided in the physician's office." Direct cost is defined by the PPRC as including "clinical staff salaries, a share of office staff salaries, medical supplies, and medical equipment." A review of orthopaedic practices reveals that a significant portion of clinical (nursing) staff time is directly related to hands-on patient care in the hospital—such as, bedside assistance, as well as in the pre- and postoperative phase of care. Additional services provided by the clinical personnel are listed in the attached addendum.
- Three, surgeons are compensated under the RBRVS on a "global fee" basis. This global fee includes pre-, intra-, and postoperative services. We are not sure if this concept is recognized and adequately provided for in the PPRC methodology.
- Four, the PPRC has stated that preliminary estimates suggest that the institution of this accounting principle will reduce total payments for surgical procedures by at least 25 percent. This seems to be particularly high and very damaging to surgical practices. However, one can understand that this result could occur if the "accountants" and the PPRC fail to recognize how personnel are used in surgical practice, thereby placing them in the wrong "cost" category. We do not view accounting as a precise science; thus, if the assumptions are incorrect from the start then the results will be distorted and damaging not only to the surgeons but to access for all Medicare patients.

We urge the Subcommittee to take into account the following questions as it pursues this accounting principle:

1. How will this methodology affect the Medicare/non-Medicare case mix of surgeons who are already experiencing drastic fee reductions for the particular surgical services they perform?
2. How will the methodology affect solo and small-group practices, many of which are located outside of major metropolitan areas? (These practices are likely to have a significantly different mix of practice expenses compared to large group practices.)

3. How will the methodology affect the surgeon's ability to maintain the infrastructure of his or her practice? Would surgeons be more or less likely to reinvest in their practices?
4. Will the study of direct costs associated with a procedure be of sufficient detail and structure to capture the "true" cost of providing that service?
5. How will the implementation of this accounting concept advance the objectives of the Congress to improve access and to provide affordable health care to Medicare patients?

We urge you to carefully examine prospectively the impact of any further changes to the recently instituted Medicare Fee Schedule. More than ever before, this type of analysis has to be an important component in determining payment approaches, regardless of how sound they seem from an accounting perspective prior to any thought of implementation.

Single Fee for Surgery

The vast majority of surgeons use assistants at surgery because it is in the best interest of the patient—and this should be the only criterion for their use, not cost savings. When needed, assistants at surgery are vital to the successful outcome of an operation. We believe that the Administration's proposal sends a strong message that Medicare patients are not entitled to quality care when the circumstances call for surgical assistance. Even though the proposal would allow for assistants in "particularly difficult cases," it is unclear what this means, since assistants are needed when they are needed—not just in difficult cases.

As the Subcommittee members are aware, payment levels for physicians who serve as assistants at surgery have already been reduced from 20 to 16 percent of the fee, with associated reductions for non-MD assistants. Assistants do not receive any payment for procedures where Part B claims for them are filed in less than five percent of the cases.

The Administration's "shot gun" approach would only lead to quality care disincentives, and the Academy urges the Congress to reject it. Instead, we support the position taken by the PPRC. We believe that to reduce overutilization of assistants, physician profiling and educational approaches should be implemented.

Physician Ownership and Referral

The Academy recognizes the importance of addressing the issue of physician ownership and self-referral, and we commend the Chairman's efforts to respond to this matter. Like you, we believe that self-referral solely for financial benefits is unethical. But, it must be noted that in most instances physician ownership arrangements do not result in inappropriate utilization. Often, they improve quality of care, enhance patient convenience, and may actually reduce costs. However, we appreciate your recognition of the exemption for in-office services. Effective patient care dictates that certain related health procedures be performed in the orthopaedic surgeon's own office. To provide essential orthopaedic care, physical therapists often are employed on the premises.

In a matter related to physician referral, treatment of musculoskeletal disorders is predicated in large part upon the correct interpretation of x-rays. Orthopaedic surgeons are highly trained in this skill. Good patient care dictates that x-rays be taken and interpreted efficiently and in a timely manner. Patients with musculoskeletal complaints, especially those with limited mobility, should not be made to suffer more by having to travel to other facilities for x-rays, wait for their x-rays to be taken and interpreted by a radiologist, and then wait for their x-rays to be sent to the orthopaedist for his or her interpretation. The Administration's proposal to ban all self-referral, thereby eliminating the orthopaedist in-office x-ray, would produce just such delays, inefficiency, increased cost and suffering to Medicare patients.

Conclusion

In conclusion, we recommend that the Congress maintain the current approach to calculating practice expenses under the RBRVS until a sound methodology, with adequate supporting data, is available. We recommend that assistants-at-surgery continue to receive a separate payment for their services, without reducing the primary surgeon's fee as the Administration proposes. And, we urge the Congress to modify the Administration's proposal concerning physician ownership and referral, as to not jeopardize quality of patient care.

Mr. Chairman, we recognize the difficult policy considerations which must be faced when addressing the financing of health care coverage under the Medicare program. The American Academy of Orthopaedic Surgeons stands ready to assist your Subcommittee in developing legislation to improve the cost-effectiveness and quality of health care in our country, and we thank you for the opportunity to participate in this hearing.

Chairman STARK. Thank you, Dr. Stanley.

You have all presented your testimony. I am sorry that some of our colleagues miss us and they want us to come over and vote frequently, and it disrupts our proceedings somewhat.

I just have one comment I made for the record when I addressed many of your colleagues yesterday. I appreciate the willingness of the physician community to participate with us in what is not going to be an easy legislative exercise. I hope that this initial offer of participation extends for the duration.

There is always the chance that any of us, the Congress, the physician community, the hospitals can just walk out, and I don't know what happens then. That could end the procedure or it could lead to less effective health reform.

The Chair has been committed to try and keep faith with those tenuous bargains that were struck in our reimbursement program, and insofar as I am able to encourage my colleagues to do so, I think it is important that we do. I think this committee has tried to bail out some mistaken directions on EKG reimbursement. Whether or not we thought that was right or fair, it was a deal.

I think we have said repeatedly to the leadership of your various associations that we will keep a deal, but the day will come when we will have to be suggesting to you perhaps more serious cuts, and that is never fun. This may be the year we have to do that, and I hope we can continue to negotiate those cuts in the best and most open way we can. We all wish the economy were better and we had more money to take care of the uninsured, but the fact is we do not.

There is some tendency, as we do in tax writing, to say don't cut me, don't cut him, cut the man behind the tree. So the hospitals

in some prepared testimony, it was suggested that maybe we should cut them a little more.

All I can say is, as we have glanced at the President's initial proposal, there seems to be some fairness or some relationship to previous expenditures, and so I would like to think that initially we haven't singled out, with the exception in the President's proposal those particular procedures which were identified for one reason or another as being overpriced.

That is the only comment, but I now want to ask a question or two. First of all, I want to make sure that my universe is statistically solid. Are there any of you who were not in practice in the early 1970's, when we had the Nixon price freeze? You were all in there taking care of your patients in 1971-72, so you all participated in that, is that correct?

Dr. SEWARD. Yes, sir.

Dr. TUDOR. I was operating a teaching program and was not dependent on practice income.

Chairman STARK. But you went to the locker room and talked with the gang? You knew how they felt about it.

Dr. TUDOR. I had to collect fee-for-service, also.

Chairman STARK. I think this is going to be a realistic choice. I have no inside information, and I understand you are now going to the White House five times as a group of physicians between now and May. Let me know what you find out. [Laughter.]

But what the reporters are telling me is there are three choices for how we are going to control costs; control insurance premiums, use cost controls similar to the Medicare system, or do a price freeze.

The insurance proposal I would submit to you is not likely, because it will not be scored. Whether we take it off the table or they take it off the table, there will be no budget savings that they can add up. So I am not being arbitrary when I say it won't work, I am just saying that empirically it cannot.

Would you mind just telling me, if you had your choice between extending to your entire practice and to your colleagues—I won't say that this is a vote of your association—but if your choice were the cost controls under the current Medicare procedures, not necessarily at Medicare rates, or the freeze under the basis as you could remember as we had in the early 1970's, which poison would you pick? How many would pick the cost control? One.

How many would pick the price freeze? One. [Laughter.]

Well, so much for negotiation. Dr. Seward.

Dr. SEWARD. Baruba—a Hobson's choice. [Laughter.]

Chairman STARK. I hope that if you are not unwilling to let the record show that there were four abstentions and one for cost controls and one for price freeze.

The next question I have is that there has been much discussion in the area of managed competition, but how would all of you feel if, in the end result of our health reform, in whatever organizations were authorized to bid on behalf of consumers for medical care, you would all be restricted to one program or one plan in your area? In other words, those of you who are specialists would not be able to sign up to serve two HMO's.

CBO has indicated in its testimony that the only conceivable way we would get any cost savings out of a managed competition is if we restricted physicians, and particularly the specialties, to a plan, so that you couldn't be on several boards. Would that be acceptable to all of you?

Dr. SEWARD. No.

Chairman STARK. Anybody to whom it would be acceptable?

Dr. SCOTT. It might be acceptable.

Chairman STARK. It might be acceptable in primary care.

Dr. SCOTT. Yes.

Chairman STARK. Now, the real kicker is there are those in the managed competition arena who would tell you that basically it can't work unless all of you are willing to take patients on a capitation basis. Now, would that be a good plan and would you all be willing to accept that. Would you be willing to accept patients or accept a plan that said you must have capitation contracts? Assume there were bonuses in it, but no outstanding huge personal liability risks.

Dr. Tudor.

Dr. TUDOR. That is a hard question to answer, because we don't know what the capitation payment is or what the population is that you are serving. I think that really relates to the accountable health plan developing its own management system that fits its market and service area.

Capitating at the level of the plan is one thing, because it spreads the risk. But capitating at the level of the individual provider may result in adverse selection, and I may end up with a lot of sick Medicare nursing home patients who require more time. It would take years to adjust for that.

Chairman STARK. That is exactly why I think you would be limited to one plan. I think that was the idea, to prevent the other side of adverse selection.

Dr. TUDOR. Well, if I am limited to one plan, I am more or less an employee entirely at the plan's bidding. I have no options, no negotiating power at all, and unless I can form an association of physicians that really has equal negotiating power with them, I have no leg to stand on.

But with multiple plans, I can choose the one that treats me best, treats my patients best, treats the economy best, and I would not have to be stuck in one place.

Dr. BLOCK. It also would allow the patient a choice. That is basic to our understanding of this, that patients must have freedom of choice of their physicians.

Mr. McDERMOTT. Mr. Chairman, would you yield?

Chairman STARK. I would be happy to.

Mr. McDERMOTT. I want to follow up with a question to Dr. Tudor. Why would you want a situation where you could join three or four or five different plans, as opposed to getting the State medical association or the State specialty association to negotiate for you? In other words, why not negotiate with one voice, all of you together? Why would you rather stand on your own two feet? What is the advantage to you?

Dr. TUDOR. Well, there are two or three problems. One is that at present we do not have the right to negotiate as an IPA or as

a medical association with a plan. There is an antitrust problem and we would have to have some relief from that.

If there were multiple plans, how is a the medical association going to negotiate for a pool of all doctors with plans that have different management systems? I need to negotiate with the plan that I am signed up with or, maybe, in the spirit competition, play one plan off another. I could say "I like your way of doing business better," or alternatively, "why don't we improve on the situation?" I don't think we can just put all doctors together and all consumers together and expect anything to come out of it.

Mr. McDERMOTT. So you figure you will negotiate a better deal on an individual basis than you would bargaining collectively as all the general practitioners or all the ophthalmologists or whatever?

Dr. TUDOR. I can't visualize all collectively negotiating with different plans. People participating in one plan, negotiate with that plan. But in going to the medical association and having it negotiate for me with everybody, I think I might find that my fee schedule is being delayed, because other people benefited from that delay.

Chairman STARK. Dr. Block, you started to suggest that it was critical in your acceptance of this that there be the ability of individuals to select their physician and, if they choose, I presume, select a fee-for-service alternative. Is that your statement?

Dr. BLOCK. Yes, sir.

Chairman STARK. Would you consider a plan in which somebody selecting an individual physician on a fee-for-service basis had to pay a penalty like increased income tax or a higher premium to do that? Would you consider that free choice?

Dr. BLOCK. Yes, I would. It is a modification of free choice, but it is a model that has been used around the world and successfully. If the alternative is not having free choice, I would certainly have some type of an up-front payment that would allow that free choice for those who would elect it or who could afford it.

The other problem with these multiple groups that we are talking to Dr. Tudor about is that, to date, I don't know any HMO that has not been selective in its membership. So the ones that you would be negotiating with could be entirely different panels of HMO's. To have one group as a perfect HMO model has not yet existed.

Chairman STARK. If, as you suggest, having to pay extra taxes on the benefits or having to pay a higher out-of-pocket fee to join a fee-for-service plan as opposed to an HMO, aren't you effectively denying fee-for-service options to low-income and impoverished people under that program?

Dr. BLOCK. I would think that a provision should be built in that, for those who could afford it, that option exists. For those who could not afford it, the option still exists with no cost. After all, we are seeing patients in every specialty now who are indigent, who come from a long way away. We are taking care of them gratis—and that has been the tradition of American surgery and it will continue, hopefully.

Chairman STARK. So what you are suggesting is that it would not be proper to basically force a two-tier system based on economic—

Dr. BLOCK. A two-tier system would be appropriate, but have the ability for all patients, whatever their economic circumstances, to select the physician they wish to take care of them. Or, if they were unhappy with the care that they were receiving, to get another opinion or another treatment outside of the system. I think that is extremely important for the quality of care in our system.

Chairman STARK. In other words, your feeling is that if you were in a system in the District of Columbia, that no resident of the District of Columbia should be denied the option of going to Johns Hopkins?

Dr. BLOCK. If I want to go to Johns Hopkins or the Mayo Clinic or New York—

Chairman STARK. Palo Alto, Jackson Hole.

Dr. BLOCK. I would suggest even the University of Chicago.

Chairman STARK. I agree with you.

Dr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman.

I want to do a little philosophy here with you that is related to this whole business, and I will ask you to accept a basic premise, and then if you do not agree with that premise, you can argue the premise.

The basic premise is that American medicine has more specialists than they need, as opposed to the rest of the world. The numbers are almost exactly reversed in every other system. When you try to control costs, you try and get more primary care people into the system.

If you accept that basic premise, what incentive can you think of besides money to change the way medical students choose their residencies or choose their practice? I give you one fact, that in 1989, 23 percent of medical students were choosing family practice, and today it is down to 19 percent. So the numbers are not going up, the numbers are going down. Everybody is going into specialties. I assert that it is probably on the basis of paying off debts, as much as anything, but there may be other reasons.

How are we, as policymakers, going to get to a place where we have 50-50 family practitioners or primary care physicians to specialists, or as in other countries where it is 70 percent family practice, other than money? Is there any way to do it besides money?

Dr. SEWARD. Can I start off, Dr. McDermott?

Mr. McDERMOTT. Go ahead.

Dr. SEWARD. I am sure my colleagues will have additional comments here.

Number one, the economic decision is not the main determinant of that. One of the economic decisions, for instance, that I think you can legislate that would help is once again getting back to the tax deductibility of the loan for students.

There are other incentives. I happen to be in family practice and chose it because I wanted to be a family practitioner. But I heard a statement earlier this morning that bothered me from a personal standpoint, saying that you have just x number of residencies and if you didn't get to be whatever specialist, then you could be a family practitioner or a pediatrician.

My opinion is that this is a bad way to choose to go into the specialty that I really enjoy. If you wanted to be an anesthesiologist,

you probably are not going to make a very good family practitioner, if that is what you wanted to do.

I think that there are areas of isolation that we have to address. An area of concern, when we train our primary care people is whether or not they will have the technology when they go to the rural areas or the inner-city areas. So there is a multiplicity of issues there, from a policy standpoint.

Now, to speak specifically for the AMA, the AMA has policy that the percentage of primary care physicians should be increased. What number is absolute, Dr. McDermott, I don't know. It probably needs to be changed from what it is, but I can't tell you exactly what the number should be. And, needless to say, to talk about professional birth control is not appropriate for me. However, it would be our policy to say that we do need more primary care physicians.

Mr. McDERMOTT. Do you think it can be achieved voluntarily, or do we have to say from now on we will fund only 30 percent of our residency slots in specialties and 70 percent will be in family practice, in order to redress the imbalance we presently have?

Dr. SEWARD. I am going to defer some to my colleagues on this. I think just doing that may not be the only incentive that will work in that area. On the pure economic matter of which residencies you are going to fund, I am sure Dr. Tudor can probably speak to that in more detail than I.

Dr. TUDOR. May I go ahead now?

Mr. McDERMOTT. Sure.

Dr. TUDOR. I think there are three factors that are particularly important, and some are being considered in what we are discussing here today. The first, obviously, has to be income disparity, which is not the actual income, but how much better off you can do in some fields rather than others. As the American College of Physicians witness said, there may be a several hundred percent difference in income for the same amount of work.

While this sends a clear signal to medical students, this year we have seen a one-time turnaround in the student interest in family practice. The number of positions filled last week jumped from 67 to 77 percent, a net increase of over 300 students choosing family practice residencies.

Mr. McDERMOTT. The selections were just done.

Dr. TUDOR. Just announced last Wednesday. I think they are reading the subtle signals. Family practice and primary care is coming into its own. There are better employment opportunities with HMO's now, the fee schedule is being revised, they think, and those things are influencing their choices.

If we do not maintain the progress, if we get across-the-board cuts, if we get delays in the updates, I think medical students may become somewhat cynical again.

The second factor is the system, such as the impact of GME funding on where the health care is provided. It has been asked how inner-city hospitals could meet their manpower needs. You know, perhaps the situation would be different if the funding incentives were not to have residents making inpatient rounds or in the operating room so that teaching hospitals can get your money to pay for underserved and underfunded people. Currently, the

time the resident physician who leaves the hospital to go to a family practice training center is not counted. He is no longer contributing to inpatient care, and he is no longer reimbursable to the hospital. The hospital no longer wants to have him around or on the payroll. Providing the care out there in the neighborhood might be more cost effective than having that same patient come into the university hospital clinics and get bounced around from place to place or come into the emergency room in the middle of the night. There is a positive impact on the whole system by providing more generalist care at the medical center itself. That is tied into GME financial incentives.

Third is the medical school curriculum. What goes on in medical schools is probably not germane to what we are discussing here today, but the incentives and prestige at medical schools has been research and technology. It has been these things for which you are promoted, what you are recognized for, what you are honored for, what you are paid for, and that is reflected in the way medical schools are run.

Dr. BLOCK. Dr. McDermott, I would have to disagree a bit with your premise in order to make my point. I do not believe that history tells us that any type of financial reward has driven medical students to one discipline or another. The attempts at financial reward have been unsuccessful in the past.

The European model that you talk about is a very highly structured model, as you know, where competitive examinations are given and only the best and the brightest so-called of these foreign countries are allowed to go into certain specialties that have set a very small limit, and the structure in the medical profession as far as specialist accessibility to the patient is concerned is not the way that we have it in this country. I think it would be quite unacceptable to the American population.

But I would agree with Dr. Tudor that the way to increase the number of physicians in any specialty, whether it be primary care or the most arcane subspecialty, is with role models, the prestige, the way those things are presented in the early years of training. I still perhaps am a Polyanna, but I believe this influences these very bright and very idealistic medical students more than a tax refund on a loan down the line.

The questions to ask are: Who is your role model? What am I doing for society? How interesting a job in medicine do I have? If that primary care physician is going to be a gatekeeper and merely a jobber pushing abdominal pain to a surgeon, leg pain to a vascular specialist, no, you are not going to have anyone go into that type of thing. If they are doing a job that interests them, that has the reward of prestige, position, interest, role models, then you will have these positions filled.

Mr. LEVIN [presiding]. I think we had better go on. If it is all right, Dr. McDermott, I think we had better go on.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. We do have a vote on and I apologize for missing most of your testimony. I have tried to read as much as I could.

It seems to me the single thread runs through your testimony, and I want you to comment on this and tell me if I am wrong. It

seems to me that the common thread is if we in Congress continue to micromanage your practices through ratcheting down on Medicare procedures, payments and so forth, that it will affect the practice of medicine and the quality of care in a very adverse manner.

Am I wrong in that? If I am, tell me. If I am right, please expound on that. Are you going to have more physicians opting out of the Medicare system, are you going to have fewer of the best and brightest students going to medical school. I mean just expound on it.

Dr. TUDOR. I would be happy to take first shot at that. I think you are exactly right, that there is a dissatisfaction among physicians, because what was promised with the RVS and what was promised with the fee schedule has not come to pass. HCFA made some mathematical adjustments that made it come out, as Senator Rockefeller said yesterday, "not the way we wrote it, not the way we intended it." And to hold back on updates and correction factors at this point would further reinforce that message.

We were told that family practice was going to benefit from this, but, you know, guess what? The specialists are going to get cut a lot, and you guys are not going to get anything out of it. It turns out that during the first 2 years that is about what has happened. Specialists took a bit hit, and we have gotten very little improvement. This has been because of the historic practice cost factor, the geographic practice cost index, and a number of other adjustments that HCFA placed on it.

I think that we will see physicians who are now carrying Medicare patients at or below cost to stop taking Medicare patients very soon. They are hanging on. They are waiting to see what is going to happen next, but they cannot continue forever. They are going to close their practice or close it to Medicare patients.

Dr. STANLEY. Mr. McCrery, I would presume to hasten to seize the opportunity to agree at this point with Dr. Tudor, as I have on many other points in the past, on the problem that we see in the medical community in our sphere, the surgical community with micromanagement, we attempt generically, as organizations, as groups of physicians, to meet the obligations which are imposed, for example, to expenditure targets rather recently, as you very well know, the surgical community has been first-round successful in doing so. And now to perceive a desire to, if you will, partially at least scrap the system and for budget reasons quickly do further reductions is disconcerting, to say the least, and it is confusing and it is disappointing.

Dr. SEWARD. Mr. Chairman, from our perspective at the AMA, we would have to say that the micromanagement is real. When you look at the Medicare law that right now is literally thousands of pages, and the regulations are extremely obtuse at times, there is constant micromanaging. This is a patient care issue, as it does reflect eventually on my mission in taking care of patients.

I think we have to always remember—and I am looking at it from a broader perspective and I agree with my colleagues already on this—that there are a lot of other things driving the system as far as costs. When you try to micromanage, you forget some of those other driving issues like technology and aging and lifestyle and liability and public expectations. When you try to micromanage

to handle all of those, there are going to be troubles with that. I think we need to address those other factors driving the cost motors.

Mr. LEVIN. Let me just suggest, because we have a vote on, go ahead if you would comment briefly, because I want to make a brief statement.

Dr. BLOCK. Mr. McCrery, the RBRVS is partially successful and partially not. The RV is successful—that is, the notion of a relative value scale is sound. The RB is not. The volume performance standard is successful, in our opinion. The baby should not be thrown out with the bathwater in this situation. Attempts at micromanagement, as Dr. Tudor has pointed out, have been failures.

If we need a budget reduction, then I think it should be across the board, without trying to micromanage the programs. All participants in the health industry—nurses, doctors, technicians, social workers, psychiatric social workers, drug companies, instrument makers, the whole bit—ought to be affected equally, without prejudice or reward, while keeping the beneficial and good aspects of the present system as identified by the MVPS and the RV section of the RVRBS. The RB, especially as it applies to practice costs, is yet unexplored territory.

Mr. LEVIN. Let me, if I might, just say a word, and then I need to leave. Mr. McCrery and I have to vote.

I think we need to be realistic. This subcommittee has to find \$50 billion more or less in savings. That is in a budget resolution we passed that is coming back from the Senate and will become law.

And you can call the proposals micromanagement. The alternative will be across-the-board cuts within the Medicare system—within the Medicare system. That is going to be our responsibility. And so I would hope very much that we could join together.

I was going to ask you to kind of show your hands. Some of you have already voted through your testimony on the six, seven items that I was going to ask you.

You support few of these. Some of you oppose all of them, I think. And the only alternative will be an across-the-board approach, a freeze approach, within the Medicare system, and I think you might find that less acceptable. That \$50 billion: more or less figure is essentially a fact of life, OK. It really is. And I think the testimony today has not assumed that, and we are going to have to be busy on that in the next weeks, so I hope we can work together to find a solution.

Thank you, Mr. Chairman.

Chairman STARK [presiding]. Thank you.

I want to thank the panelists very much. I look forward to working with you.

There is a comment made in the speech by a highly-placed administration official that says, and I quote, that they “are going to solicit the views of hundreds of health care interest groups, but what we will not do is put them at the decisionmaking table.”

I want to assure you, gentlemen, you are always at our decision-making table.

Dr. SEWARD. Thank you, Mr. Chairman.

Chairman STARK. Our second panel includes five more representatives of physician associations. They are Dr. Richard Ruppert, the president of the American Society of Internal Medicine, accompanied by the Society's executive vice president, Dr. Allan Nelson; Dr. Allan Jensen, the secretary of Federal Affairs, the American Academy of Ophthalmology; Dr. Wallace, chairman of the American College of Radiology; Dr. Peter McDermott, president of the American Society of Anesthesiology; and Dr. Donald Senhauser, president of the American College of American Pathologists.

Gentlemen, welcome to the committee, and I will ask you to proceed in the order that I called your names, so we will lead off with Dr. Ruppert.

STATEMENT OF RICHARD D. RUPPERT, M.D., PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE; ACCOMPANIED BY ALLAN R. NELSON, M.D., EXECUTIVE VICE PRESIDENT

Dr. RUPPERT. Thank you very much, Mr. Chairman, for the opportunity to present our testimony.

I am Dr. Richard Ruppert, president of the American Society of Internal Medicine. I am also president of the Medical College of Ohio of Toledo, in charge of multiple residency programs. In that capacity, I just had an interview with all of our students in the Match program, and perhaps later we might discuss their opinion about the Match and their decisions about choice of speciality.

You may be hearing from some groups today that we need to reject further Medicare savings. ASIM is not one of those.

On February 24, we sent a letter to President Clinton, expressing support for his efforts to achieve a balanced and fair deficit-reduction package. As part of this package, policies to reduce the rate of increase in Medicare expenditures are acceptable, providing we look at several very important principles from ASIM's point of view.

One, that savings should not be allocated solely to deficit reduction, but also to expanding access to health insurance coverage.

Second, that services that are already underpaid—and I refer primarily to the primary care specialties—and that are experiencing access problems as a result should be exempted from further cuts. I believe we need to address those now and not later.

And third, limitations on increases in spending on physician services should be part of a balanced package that involves all beneficiaries, taxpayers, suppliers, and others to do their part in the deficit reduction.

And the fourth item is that policies to achieve the savings goals should not result in further micromanagement of physicians' practices.

President Clinton's Medicare proposals are generally consistent with the above principles. ASIM specifically supports and commends the President for proposing that primary care services be exempted from the proposed reductions in next year's fee schedule update.

Last week, ASIM released a major new White Paper entitled "Rebuilding Primary Care: A Blueprint for the Future", which I believe we have mailed to all of the members of this committee.

It explains why primary care is in trouble, and part of that has to do with a survey we have done of our membership, as well as students, and provides 44 specific recommendations for rebuilding primary care.

One of the key recommendations is that primary care services should be protected from further budget cuts, as President Clinton has proposed. And in that report, we also include discussion on a recommended approach to primary care training in internal medicine.

You will likely be hearing from others that a more fair alternative to the administration's proposal cuts will be for Congress to enact an across-the-board limit, freeze, or delay in the 1994 Medicare fee schedule update.

ASIM strongly disagrees with that position. Nothing could be more unfair than freezing in place a payment schedule that undervalues primary care and other visit services. We urge support of the President's proposal to provide a full 1994 fee schedule update for office, nursing home, and home visits and reject the calls that will be presented in the guise of fairness for an across-the-board freeze or delay in the 1994 fee schedule update.

ASIM also supports changes in the Medicare volume performance standards to create incentives for primary care and other evaluation and management services. Instead of lowering the default VPS, volume performance standards equally for surgery, nonsurgery, and all services, as the administration proposes, ASIM instead urges this subcommittee to either support a single volume performance standard for all services or work toward the establishment of separate high volume performance standard for evaluation management services and a higher default update for primary care visits.

ASIM strongly supports mandating that practice expenses under the Medicare fee schedule determined by relative value units that are based on resource cost, as has been discussed earlier, and not just on historic charges. The administration's proposal to begin phasing in this change in a way that will lower the practice expense for relative value units for some overpriced services, without raising them for undervalued visit services.

We urge the subcommittee to instruct the administration to begin phasing in a resource-based practice expense methodology in a manner that provides for increase in the practice cost relative value units for undervalued evaluation and management services, but that would maintain at least some of the proposed budget savings.

The methodology presented today by the Physician Payment Review Commission for determining which services are overvalued may offer advantages over the administration's methodology by avoiding the dangers of cutting the practice expense relative value units for some services, such as office-based diagnostic procedures.

The ASIM further favors restrictions on potentially abusive self-referrals. On the other hand, we believe that shared laboratories, in-office diagnostic procedures, and some other services should be exempted from those further restrictions.

Although we support the overall balance in the President's package, several of his proposals should be carefully evaluated prior to

implementation. We specifically urge the subcommittee to require that Health and Human Services monitor the impact of proposed laboratory fee schedule cuts on access to in-office testing. If the data shows that physicians are being forced to close their labs due to lower fees and the cost of complying with CLIA, the proposed cuts should be reconsidered.

In conclusion, as long as the proposed package remains true to the principles that I have outlined at the beginning of this statement, ASIM will remain supportive of reasonable reductions in Medicare outlays. We urge the subcommittee to assure that the final package that is enacted by Congress does not depart from these principles.

Finally, the subcommittee should consider including in reconciliation legislation of many of the other proposals in "Rebuilding Primary Care: A Blueprint for the Future."

Eighteen of the recommendations are for changes in Medicare policies which fall within the subcommittee's jurisdiction. Protecting primary care from further cuts is a step in the right direction, but much more must be done to alter an economic, regulatory, and training environment that is now hostile to primary care.

Thank you very much. I would be glad to respond to questions later.

[The prepared statement follows:]

American Society of Internal Medicine

Testimony

to the

Ways and Means Committee

Subcommittee on Health

on

Medicare Part B Budget Issues

March 25, 1993

Introduction

I am Richard Ruppert, MD, President of the American Society of Internal Medicine (ASIM). ASIM represents 26,000 internists nationwide who provide primary and subspecialty care to Medicare patients. I am pleased to share with you their views on President Clinton's recommendations on Medicare Part B budget issues.

Let me begin by thanking you for the opportunity to testify. Because internists are among the principal providers of services to Medicare patients, they have a particular interest in recommendations that may affect their ability to provide Medicare patients with the services that they need. Many, however, have a strong sense of disenfranchisement and disillusionment with the policies coming out of Washington. They often ask "Is anyone listening?" to what they have to say. By inviting ASIM to participate in today's hearing, it shows that Congress is indeed interested in hearing constructive recommendations from those practicing physicians who have the major responsibility for providing primary and subspecialty care to patients enrolled in Medicare. It allows us to tell members that the door is indeed open to them.

My testimony today will emphasize the importance of working constructively with Congress and the administration in this time of great change. Internists have great anxiety about how they and their patients will be affected by the changes being contemplated. But they also have a great sense of commitment toward achieving workable solutions for their patients. There will be times when ASIM, on behalf of its members, must and will oppose proposals that we believe to be unfair or unworkable. But we prefer to be able to work with Congress and the administration towards achieving consensus on the changes that are needed.

It is in that spirit that ASIM has considered the President's Medicare proposals. You may be hearing from many others who reject out-of-hand the President's recommended changes in Medicare. ASIM is not among them. Instead, on February 24 ASIM wrote to President Clinton and stated our desire to work with him in a constructive manner on his deficit reduction plan. There are some proposals in the plan that ASIM supports, such as the proposed exemption from cuts for some visit services.

Although ASIM supports appropriate measures to allow for deficit reduction and expanded access, internists are concerned that continued cuts in Medicare will compromise their ability to provide patients with appropriate care. Too many cuts, especially if targeted at the wrong expenditures, could be highly detrimental to Medicare patients. Consequently, ASIM's support of the administration's and Congress's efforts to reduce the rate of increase in Medicare expenditures is predicated on the following principles:

1. **Savings In Medicare should not be allocated solely to deficit reduction, but also to expanding access to health insurance coverage.** Internists will be far more willing to accept limits on Medicare spending increases if they perceive that the savings will be used to expand health insurance coverage for those who are now unprotected, rather than solely to reduce the deficit or to allow for increased spending in areas other than health.

2. Services that are already underpaid--and that are experiencing access problems as a result--should not be subjected to further Medicare cuts. Instead, savings should be achieved from other services that are paid too high, and where there is little risk of access problems being created if payment increases are restrained.

3. Efforts to limit increases in Medicare spending on physician services should be part of a balanced package that also asks beneficiaries, taxpayers, suppliers, and others in the health industry to also do their part to reduce the deficit and expand access. Physicians should not be singled out for an unfair proportion of the Medicare savings that will be required to reduce the deficit and expand access to care.

4. Specific changes in authorizing legislation that are needed to achieve the savings goals must be carefully scrutinized, prior to enactment, to assure that they do not result in further "micromanagement" of physician practices or result in denial of payments for legitimate services. In 1990, when Congress and the President last reached agreement on a major deficit reduction package, the result was enactment of several provisions that denied payment for legitimate services. A last-minute addition to the OBRA 90 Medicare spending cuts resulted in elimination of payments for EKG interpretation, which has disrupted the ability of physicians and hospitals to arrange for qualified interpretation of this important diagnostic test. OBRA 90 also included unfair limits on payments to new physicians. It is essential that Congress not only correct these mistaken policies, but that care also be taken so that similar mistakes do not occur this time around.

For the most part, ASIM believes that President Clinton's Medicare proposals are consistent with the above principles. The package exempts certain undervalued primary care services from the proposed cuts, targets most of the reductions toward services that have been paid too highly, requires each of those with a stake in Medicare--physicians, hospitals, durable medical equipment (DME) suppliers, and taxpayers--to contribute toward the savings, and generally avoids proposals that would result in micromanagement or denial of reimbursement for legitimate services. It appears, however, that all of the Medicare savings will be devoted to deficit reduction, not expanded access. And ASIM remains concerned that the balance struck in the package may be altered in Congress as other groups oppose cuts that adversely affect their interests.

I'll now share with the subcommittee ASIM's specific views on the President's Part B Medicare proposals.

The Medicare Budget and Primary Care

ASIM specifically supports--and commends--the President for proposing that primary care services be exempted from the proposed reduction in next year's fee schedule update. Under the proposal, primary care services (which in the past has been defined in statute as office, nursing home, and home visits) would in 1994 receive the *full* fee schedule inflation update required under current law. All other services would receive the current law update minus two percent. If enacted by Congress, this would represent the first time in three years that some primary care services received an update that is at least equal to inflation. The 1993 update, by comparison, was only .8 percent for visits and other nonsurgical services but 3.1% for surgery.

Exempting primary care from further cuts would be an important first step toward alleviating the growing crisis in access to primary care. Last week, ASIM released a major new white paper "Rebuilding Primary Care: A Blueprint for the Future." The paper explains why primary care is in trouble, and what can be done about it. A copy of the paper has been sent under separate cover to the members of this subcommittee.

I do not intend to take up your time today with a detailed presentation on the paper's findings and recommendations. There are a few key issues that apply directly to your consideration of Medicare budget issues that I will mention, however.

In reviewing the research literature to prepare the paper, we found that the number and proportion of physicians in primary care has been steadily declining. Even more disturbing, the trend is getting worse. Citing numerous studies, the paper reports that:

- The proportion of physicians who are in the primary care specialties of internal medicine, pediatrics, and family practice has declined from 50 percent in 1963 to only 34 percent today.
- Only 14 percent of medical students surveyed in 1991 intend to go into primary care.

- If current trends continue, within a decade fewer than 20 percent of America's physicians will be in primary care.
- Costs will be lower and care will be better if there is a greater number and proportion of internists and other primary care physicians.
- The principal factors driving physicians away from primary care is a hostile economic and regulatory environment and a training system that encourages overspecialization.

The paper provides 44 specific and detailed recommendations for rebuilding primary care. Because Medicare has a disproportionately larger impact on internists than other payers, 18 of the recommendations are for changes in Medicare's payment and regulatory policies.

One of the key recommendations is that primary care services should be protected from further budget cuts. The paper notes with approval President Clinton's proposal to exempt office, nursing home, and home visits from the reduction in next year's update. But the paper also cautions that as groups raise objections to other Medicare cuts, the higher update for primary care that the President proposes could be at risk of being reduced. This would occur if Congress rejected some of the cuts and made up the lost saving by lowering the primary care update.

You will likely be hearing from some of the other groups testifying at today's hearing that a "more fair" alternative to the administration's proposed cuts would be for Congress to enact an across-the-board limit, freeze, or delay in the 1994 Medicare fee schedule update. ASIM strongly disagrees.

Nothing could be *more unfair* than freezing in place a payment schedule that undervalues primary care and other visits services and that pays too much for many other services, or in delaying the update for primary care services. If, in order to ease the cuts in other areas, office, nursing home, and home visits are not given the full update proposed by the administration, it will be yet one more signal that the federal government is not yet willing to take the steps needed to begin to rebuild primary care. By doing so, the trend away from primary care will be exacerbated.

ASIM believes that the administration was right to recognize that if additional Medicare savings are needed, they should come from non-visit services that are being paid more highly, and for which there is no evidence (unlike primary care) that patients are likely to experience problems in obtaining access to those services even if further payment increases are limited. We urge the subcommittee to uphold this approach by providing a full 1994 fee schedule update for office, nursing home, and home visits, and to reject the calls that will be presented under the guise of "fairness" for an across-the-board freeze or delay in the 1994 fee schedule update.

We do believe that there is one key element of the administration's proposal that requires clarification, however. The administration proposes that primary care receive the "current law" update, and that all other services would receive the "current law" update minus two percent. This has been reported to mean either that primary care would receive the full Medicare economic index (MEI), and other services the MEI minus two percent, or that primary care would receive the MEI plus or minus actual expenditure performance relative to the nonsurgery volume performance standard (VPS), and all other services would receive the MEI plus or minus actual expenditure performance compared to the applicable VPS, minus two percent. Preliminary expenditure data reportedly indicate that expenditures for both surgery and nonsurgery fell under their applicable VPS. If this is the case, the current law update for surgery and nonsurgery would be the MEI plus an (as yet to be released) bonus payment. It has also been reported that expenditures on surgical procedures may have come under the applicable VPS by a larger margin than nonsurgery, which would mean that under current law surgery would receive a larger bonus than nonsurgery.

A higher current law "bonus" for surgery could result in the surgical update being equal to or even higher than the primary care update, even after the two percent reduction for non-primary care services that is proposed by the administration. ASIM would strongly object to an update for surgery that is higher than that for primary care. In establishing the surgery VPS, the administration assumed that a behavioral offset would occur to offset fee reductions under the RBRVS, when preliminary analyses by the PPRC and others suggest that such an offset may not have occurred after all (or at least not to the degree projected by HCFA's actuaries). Consequently, even if surgical expenditures fell below the surgery VPS by a greater margin than nonsurgery, this is likely due to HCFA's erroneous assumption of a behavioral offset in developing the surgical VPS, not because of better performance by surgeons in controlling volume.

We strongly recommend that the subcommittee seek clarification from the administration of its proposal to provide a full update for primary care and the current law update minus two percent for all other services. If the administration's proposal would result in a higher update for surgery than primary care, even after application of the two percent reduction, ASIM recommends that the subcommittee modify the proposal to provide a higher absolute update for primary care than for surgery, which we believe is the real intent behind the administration's proposal. And, under this scenario, if additional savings are needed because other proposed Medicare cuts are rejected by the subcommittee, they should come out of the surgery update, not primary care. If Congress is to begin to rebuild primary care, it is essential that primary care receive higher updates than surgery, especially given the fact that the update last year for primary care was significantly lower than for surgery.

Finally, the payment inequities that were created last year by the separate VPSs for surgery and nonsurgery, and that could occur again in 1994, point out the urgent need to modify the VPS mandate to create incentives for primary care visits and other E/M services.

Modifying the Volume Performance Standards

The administration also proposes to lower the "default" volume performance standards (VPS). ASIM supports the need to amend the VPS formula established by OBRA 89 and 90. As the subcommittee may be aware, ASIM urged Congress last year to amend the formula to preclude the separate and higher update for surgery—and the lower update for all nonsurgery, including primary care—that occurred in 1993 based on the existing statute. Unfortunately, Congress adjourned without taking any action to prevent the higher default update for surgery from going into effect. The result is that unless Congress acts to correct the problem, surgery will permanently have a higher conversion factor than nonsurgical services, including primary care visits and other evaluation and management (E/M) services.

The administration's proposal provides an opportunity to correct this flaw. Instead of lowering the default VPS equally for surgery, nonsurgery, and all services, as the administration's proposal apparently would do, ASIM instead urges that the subcommittee either support a single VPS for all services, or that it work toward establishment of a separate and higher VPS for E/M services and a higher default update for office, nursing home, and home visits. Specifically, if separate VPSs are to be maintained, Congress should:

- Amend OBRA 89 and 90 to establish a separate and higher VPS for evaluation and management services, including primary care visits. For E/M services only, the VPS should be based not only on historical expenditure trends, demographics, changes in law, and an "intensity" factor, but also on an explicit factor that is designed to allow for investment of additional spending on E/M services.
- Amend OBRA 89 and 90 to raise the default "floor" on the fee schedule update for office, nursing home, and home visits ("primary care" services) only. The current floor (minimum update) for all services is the Medicare economic index minus 2 percent. For the specified visit services, the floor could be raised to the MEI, or the MEI minus .5 percent, thus assuring that primary care would be protected even if spending exceeded the VPS for those services.
- If necessary to allow for a higher default VPS and update for E/M and primary care services and still maintain the savings expected under the President's proposal, the default VPS and update for all other services should be set at an even lower level than the administration proposes.

In its upcoming report to Congress, the Physician Payment Review Commission (PPRC) is expected to propose similarly that if separate VPSs are to be maintained, E/M services should be given improved treatment by being placed under a separate VPS.

Implementation of Resource-Based Practice Cost RVUs

The administration proposes to begin phasing in resource-based relative value units (RVUs) for services paid under the Medicare fee schedule. ASIM has been on record for several years as favoring a change in the OBRA 89 methodology for determining the practice expense RVUs under the Medicare physician fee schedule. The existing method, by basing practice expenses on historical charges instead of resource costs, perpetuates inequitably high payments for surgery and other services done primarily in the hospital setting, and unfairly low payments for E/M services. We are pleased that the Physician Payment Review Commission in its upcoming report will be recommending that Congress mandate implementation of a resource based practice cost methodology.

Although the administration's proposal also would begin moving toward a resource based methodology, it apparently would do so in a manner that would lower the practice expense RVUs for some overpriced services, without raising them for other services—especially E/M services—that the PPRC believes are underpaid under the current formula. Under the administration's proposal, by obtaining savings from interim reductions in the RVUs for overpriced services, but without increasing them for undervalued ones, there would be little or no money available to raise the practice expense RVUs for E/M services when a full resource based methodology is implemented in later years. ASIM believes that it would be highly unfortunate for a resource based practice cost methodology to be used only as a budget-cutting tool, rather than one that also results in more equitable payment for undervalued E/M services as intended by the PPRC, ASIM, and others that have supported this concept.

ASIM believes that Congress and the administration should consider an alternative that would allow for interim increases in the practice expense RVUs for E/M services, while also obtaining some short-term budget savings. The administration proposes to reduce the practice expense RVUs for all services whose current practice expense RVUs exceed their work RVUs. The practice expense RVUs would be reduced each year by 25 percent of the difference between the current work RVU and the practice expense RVU, subject to a floor (maximum reduction) of 110 percent of the work RVU. The alternative that we believe should be considered would accelerate the reduction in the practice expense RVUs for overpriced services, and lower the floor on the maximum reduction that would be permissible, with all of the additional savings being used to raise the practice expense RVUs for undervalued E/M services, especially office visits. The practice expense RVUs for overpriced services, for example, could be reduced each year by 33 percent (instead of 25 percent) of the difference between the work and practice expense RVUs, and the floor (maximum reduction) lowered to 100 percent of the work RVU, with the additional savings used to begin phasing in higher practice expense RVUs for office visits and other E/M services. ASIM also believes that the administration should publish for comment the specific services that would be reduced under its proposal, and the amount of the reduction, to allow for individuals to comment on the appropriateness of reducing the practice expense RVUs for specific services.

Another option the subcommittee could consider would be to begin phasing in higher practice expense RVUs for office and other visits, and paying for this by lowering any "bonus" update for surgical procedures that might occur under current law (even after the administration's proposed two percent reduction), as discussed earlier. This might eliminate the need to accelerate the reductions in overpriced practice expense RVUs and to lower the floor on the maximum reductions that could occur.

Regardless of which alternative is selected, ASIM urges the subcommittee to instruct the administration to begin phasing in a resource based practice expense methodology in a manner that provides for increases in the practice cost RVUs for undervalued E/M services, while maintaining the proposed budget savings if necessary.

Laboratory Fee Schedule Reductions

The proposed cuts in the Medicare laboratory fee schedule are of concern to internists, many of whom are struggling to keep open their office laboratories at a time when their costs are increasing due to the requirements of the Clinical Laboratory Improvements Act (CLIA). We believe that the administration and Congress should reassess the impact of those cuts on the ability of primary care physicians to provide their patients with quality laboratory testing. If it turns out that many physicians are in fact being forced to close their laboratories due to the high costs of complying with CLIA and lower Medicare payments, Congress should consider modifying the administration's proposal to allow for payments that are sufficient to cover the costs that physicians incur in providing their Medicare patients with the convenience of an in-office lab. To allow for Congress to make an informed judgement, ASIM recommends that Congress require HHS to study and report annually to Congress on changes in the number of labs operated by physicians and the impact on beneficiary access to those services, including an assessment of the impact of costs of complying with CLIA and reduced laboratory reimbursement on availability of in-office laboratory testing.

Self-referral Legislation

The administration also proposes to extend the ban on physician "self-referrals" to facilities other than laboratory services. ASIM supports further restrictions on potentially abusive self-referrals, provided that "shared" laboratories are exempted (shared laboratories are office laboratories that are shared by several physicians to provide testing for their own respective patients, usually located in space contiguous to their offices, but who do not otherwise meet the definition of a

group practice), since such shared arrangements are often the only way that many physicians can afford to maintain a lab for their patients. Such an exemption was contained last year in H.R. 11, which was vetoed by President Bush, and has been re-introduced as part of H.R. 21, introduced by Rep. Dan Rostenkowski (D-IL). Since the Department of Health and Human Services (HHS) does not believe that it has the authority to grant a regulatory exemption for shared labs, it is essential that Congress promptly enact H.R. 21. New self-referral legislation should also continue the current exemption for in-office diagnostic procedures, such as office X-rays, that are an essential part of a physician's practice.

Electronics Claims Processing

ASIM supports the goal of converting to electronic claims processing. Physicians should not be penalized, however, if they are unable to convert to electronic claims processing because of a lack of administrative and technical assistance from Medicare or for other legitimate reasons, such as excessive costs. ASIM strongly believes that the administration must assure that sufficient technical expertise is provided to physicians to facilitate conversion by 1996. Congress should reexamine prior to implementation the administration's proposal to begin charging \$1.00 per paper claim, starting in 1996, if it appears that physicians have not been provided with sufficient assistance in making conversion to electronic billing, or costs and other factors have precluded a substantial number of primary care physicians from making the conversion by 1996. HHS should be required to report to Congress, no later than June, 1995 on the technical assistance that has been provided to physicians, and the number of physicians who have—and have not—converted to electronic claims processing. The \$1.00 per claim "penalty" should be postponed if this report shows that a significant number of physicians have been unable to convert to electronic claims processing.

Other Part B Cuts

Our testimony today has focused on those Medicare proposals in the President's plan that will have a direct impact on internists and their patients. We recognize that some of the other organizations testifying today will express strong objections to some of the proposed cuts. There may in fact be legitimate reasons for some of their objections. The subcommittee has a responsibility to consider legitimate concerns about the President's proposals, and to consider modifications if necessary. But if some of other proposed Medicare cuts are rejected or modified, it is essential that the "lost" savings not be made up by lowering the update for office visits, nursing home, and home visits. As I stated at the outset of my testimony, ASIM will strongly oppose any effort to provide for a lesser update for office, nursing home, or home visits ("primary care services"), in order to allow for proposed cuts in other areas to be restored.

Conclusion

Even with the proposed full update for office, nursing home, and home visits, the President's proposals will require sacrifice from internists. Many of their other services will receive a less-than-inflation update, payments for laboratory services will be curbed, and payments for some services may even be reduced as a resource based practice expense method is phased in. Nevertheless, ASIM is willing to work constructively with the President and Congress on restraining increases in Medicare expenditures, as part of a balanced and fair package to reduce the deficit and expand access to care. We believe that our suggestions for modifying the volume performance standard (VPS) and default update, and for changes in the administration's proposal to implement a resource based practice expense methodology, would further the goal of rebuilding primary care while still allowing for savings.

ASIM has also suggested that some of the other proposed cuts be reexamined based on further data. We have suggested that HHS be required to report on changes in the number of physicians who offer in-office laboratory services, and if the data show that physicians are unable to maintain their office labs under the proposed laboratory fee schedule cuts and given the costs of complying with CLIA, reexamination by Congress of those cuts would then be in order. Similarly, the proposal to begin in 1996 charging \$1.00 per paper claim should be reexamined prior to implementation if physicians have been given insufficient technical assistance or other legitimate factors have precluded large number from converting to electronic claims processing. ASIM also urges Congress to require that some of the Medicare savings be used to expand access, rather than solely for deficit reduction.

As long as the proposed package remains true to the principles that I outlined at the beginning of this statement, ASIM will not oppose further savings in Medicare. To recap, ASIM believes that Medicare savings must be used not only to reduce the deficit, but to expand access; that primary care and other undervalued services must be protected from cuts; that the package must require

a fair and balanced contribution from all players, as the administration's proposal appears to require (rather than physicians being singled out for disproportionate cuts); and the savings must not be achieved through policies that would micromanage physicians practices or result in denial of payment for legitimate services. By and large, and notwithstanding ASIM's recommendations for modifying specific administration proposals, the President's package is consistent with these principles. We urge the subcommittee to act to assure that the final package that is enacted by Congress does not depart from them.

Finally, ASIM urges the subcommittee to consider other legislative changes to assure adequate access to services by internists, especially primary care internists. Exempting primary care from further budget cuts will not, by itself, encourage physicians to enter and remain in primary care (although further cuts would certainly *discourage* them from doing so). ASIM urges the subcommittee to consider the other proposals in "Rebuilding Primary Care: A Blueprint for the Future," many of which fall under the subcommittee's jurisdiction. Protecting primary care from further cuts is a step in the right direction. But much more must be done to alter an economic, regulatory and training environment that is hostile to primary care.

Chairman STARK. Thank you, Doctor.
Dr. Jensen.

STATEMENT OF ALLAN JENSEN, M.D., SECRETARY FOR FEDERAL AFFAIRS, AMERICAN ACADEMY OF OPHTHALMOLOGY

Dr. JENSEN. Good afternoon. I am Allan Jensen. I am an ophthalmologist in practice in Baltimore and secretary for Federal affairs of the American Academy of Ophthalmology. The Academy represents 19,000 or 95 percent of the ophthalmologists in the States. We also appreciate the opportunity to appear before you.

Medicare patients make up a large portion of our practices. We are concerned with the magnitude of the proposed Medicare cuts, considering the significant reductions already endured under the Medicare fee schedule.

My testimony will focus on three items. First, maintaining the current RVS practice expense calculations; second, permitting payment for assisting surgeons based on medical necessity; and third, the Academy's broader perspectives on health care reform.

We favor maintaining the current practice expense calculations under the Medicare RVS until reliable data and a reasonable methodology can be developed to accurately reflect overhead expenses. PhysPRC's recommendations for a resource-based practice expense factor provides only a conceptual model for which data could be collected. The model has not been tested. There are no national data to support it, and it does not have wide acceptance. It does not seem possible to phase in a new practice expense factor when such a factor does not yet exist.

We agree that the current method for calculating the practice expense portion is arbitrary and does not reflect the true cost of the physician's overhead. Under the current system, services performed by ophthalmologists include a practice expense factor ratio of 44 percent, based on survey data collected by the AMA in the mid-1980s. We do not know how many ophthalmologists were surveyed, what subspecialties they practiced, whether they were in solo or group practice, or how old their practices were.

The same survey established a 46 percent ratio for internal medicine and a 52 percent ratio for family practice, and yet it is our experience that it is much more expensive to equip an ophthalmologist's office than an internist's office.

We believe that an ophthalmologist's office overhead costs represent at least 52 percent of income, based on a survey conducted shortly after phase I of the Harvard RVS study was released by Dr. Hsiao. Hsiao's model for calculating practice overhead met with such criticism that he dropped that feature from his phase II study.

Despite concerted efforts, 3 years later, we still do not have a working model nor national data.

We are also concerned with the impact of these changes on surgical fees. Our estimates show reductions averaging 40 percent, some as deep as 54 percent, for the most frequently performed ophthalmic procedures, should the current formula be changed. These cuts could result in such low reimbursement that in some areas some surgeons may be unable to offer these procedures to Medicare patients.

We are also concerned about arbitrary penalties for performing services in hospital settings. PhysPRC's practice expense recommendation penalizes the physician because of services performed outside of his office, regardless of the patient's medical condition or the personnel and equipment required for optimal care. Also it does not appear to give credit for the amount of post-op care provided in the surgeon's office, a significant portion of the global fee.

We have consistently opposed site-of-service reductions, which reduces the fee for certain services performed in a hospital setting if claims data indicate that an arbitrary 50 percent of the services were performed in the physician's office. The reduction taken is also an arbitrary 50 percent off the practice expense portion.

HCFA provides no exception to the site-of-service reductions where it is in the best interest of the patient to have the service performed in the hospital, nor is there an exception for expensive services where it would be more effective to share services in a community setting such as a hospital.

Regarding assistants-at-surgery, we also recommend that you repeal the rule prohibiting payments for assistants for procedures where claims were filed in less than 5 percent of cases. The 5 percent limit is arbitrary, and there is no mechanism to allow payment for exceptional cases. Further, it is difficult to assess the actual utilization of assistants since claims data do not capture true utilization of residents in training.

We believe that the administration's proposal to reduce the surgeon's fee by the amount paid to the assisting surgeon penalizes the surgeon and the patient. Although the plan would allow additional payment in extraordinary cases, it is not clear how such a mechanism would be implemented. We believe that assistants-at-surgery should be utilized in an appropriate manner, providing an important margin of safety for the patient.

HCFA is currently developing utilization pattern monitoring which could be effective in identifying individual who might be overutilizing services. A targeted educational approach is a more effective and equitable means of controlling overutilization than are penalties and have the added benefit of preserving quality care.

Finally, the Academy has adopted a series of principles for national health care. We are also finalizing recommendations for a basic eye health benefit package, and these are included in our written testimony.

While we do not endorse any specific proposal at this time, we believe that there are a number of important principles which health care legislation should include such as universal access; insurance reforms and appropriate patient cost-sharing; patient's freedom to go outside of a health care plan to see a physician of their choice; doctors serving as managers as well as providers of care; coverage of basic benefits including medical and surgical eye care and preventive services; direct access to ophthalmologists for entry-level eye care; appropriate expenditures for outcomes assessment and guidelines development; the representation of physicians during the development and operation of any new delivery system; administrative simplification; and adequate funding for physician training.

In summary, we recommend that Congress maintain the current fee schedule formula for calculating practice expenses. We further recommend repealing the 5 percent rule on assistants-at-surgery.

We present our principles for national health care as an indication of our interest in being active participants in this important debate.

Again, thank you for the opportunity to be here, and we would be pleased to answer any questions.

[The prepared statement follows:]

STATEMENT OF ALLAN JENSEN American Academy of Ophthalmology

Good day. My name is Allan Jensen. I am an ophthalmologist in private practice in Baltimore, and Secretary for Federal Affairs of the American Academy of Ophthalmology. The Academy represents 19,000 or 95 percent of the ophthalmologists in the U.S. We appreciate the opportunity to appear before you today to discuss Medicare Part B Budget Proposals. Medicare patients make up a large portion of most ophthalmologists' practice. We are concerned with the magnitude of the proposed Medicare cuts, considering the significant reductions ophthalmology is already enduring under the implementation of the Medicare Fee Schedule.

My testimony will focus on: (1) maintaining the current RVS practice expense calculations; (2) permitting payment for assisting surgeons based on medical necessity; and (3) the Academy's broader perspectives on health care reform.

RVS Practice Expense Calculations

We favor maintaining the current practice expense calculations under the Medicare RVS until reliable data and a reasonable methodology can be developed to accurately reflect overhead expenses. The Physician Payment Review Commission's recommendation for a "resource-based practice expense" factor provides only a conceptual model for which data could be collected. PPRC's model has not been tested, there are no national data to support it, and it does not have wide acceptance. It does not seem possible to "phase in" a new practice expense factor, when such a factor does not yet exist.

Need for Further Research

We agree that the current method for calculating the practice expense portion of RVS is arbitrary, and does not necessarily reflect the true cost of the physician's overhead. Under the current system, services performed by ophthalmologists include a practice factor ratio of 44 percent, based on questionable survey data collected by the AMA in the mid-1980's. We do not know how many ophthalmologists were surveyed at that time, what subspecialty they practiced, whether they were in a solo or group practice, how old their practices were, etc. The same survey established a 46 percent ratio for internal medicine and 52 percent ratio for family practice, yet we are certain that it is more expensive to equip an ophthalmologist's office than an internist's office.

We believe that an ophthalmologist's office overhead costs represent at least 52 percent of income, based on a survey of our membership conducted shortly after Phase I of the Harvard RVS study was released by Dr. Hsiao and his associates.

Dr. Hsiao's model for calculating practice overhead met with such criticism, that he dropped that feature from his Phase II study, developing only the physician work portion. Three years later, despite PPRC's concerted efforts, and other independent studies, we still do not have a working model, nor national data.

Impact on Fees

We are also concerned with the impact of recommended changes in practice expense calculations on surgical fees. Our estimates show reductions averaging 40 percent--some as deep as 54 percent for the 20 most frequently performed ophthalmic surgical procedures, should the current formula be changed (see Attachment A). These further cuts could result in such low reimbursement, that some surgeons instead of incurring losses, may be unable to offer those procedures to Medicare patients.

We are concerned about arbitrary penalties for performing services in hospital settings. We do not support the current PPRC practice expense recommendation which penalizes the physician because a service is performed outside of the physician's office, regardless of the patient's medical condition or the personnel, equipment or resources required for optimal patient care. Also, it does not appear to give adequate credit for the amount of post-operative care provided in the surgeon's office, which is a significant portion of the global fee.

We have consistently opposed "site-of-service" reductions, which began before the Medicare Fee Schedule was implemented, and were adopted as an integral part of the Fee Schedule. This policy reduces the fee for certain services performed in a hospital setting, if claims data indicate that an arbitrary 50% of the services were performed in a physician's office. The reduction taken is also an arbitrary 50% off the practice expense portion of the fee.

HCFA provides no exception to the site-of-service reductions for cases where it is in the best interest of the patient to have the service performed in a hospital setting. Nor is there an exception for expensive services where it would be more cost effective to our medical system to share the services in a community setting such as a hospital.

As a result of HCFA's current site-of-service policy, we have already seen a proliferation of high cost diagnostic and therapeutic equipment being moved into physician offices—ultrasound for IOL measurement and lasers for retinal surgery are two recent examples. These repercussions could have the eventual effect of driving up costs to the system.

For these reasons, we urge Congress to resist making any changes to the practice expense factor in the Medicare Fee Schedule at this time.

Assistants at Surgery

We recommend that Congress repeal the rule prohibiting payment for assistants-at-surgery for procedures where claims were filed for an assistant in less than five percent of the cases performed nationwide. The five percent limit is arbitrary, and there is no mechanism to allow payment for exceptional cases, or the patient's condition. Further, it is difficult to assess the actual utilization of assistants, since claims data do not capture true utilization of residents.

We believe that the President's budget proposal, to reduce the surgeon's fee by the amount paid to the assisting surgeon, penalizes the surgeon and the patient. Although the plan would allow additional payment in extraordinary cases, it is unclear how such a mechanism would be implemented. We believe that assistants-at-surgery should be utilized in an appropriate manner, providing an important margin of safety for the patient.

We believe the President's budget proposal is an unreasonably broad approach, and not necessary at this time. HCFA is currently developing utilization pattern monitoring which could be effective in identifying individuals who might be overutilizing services. A targeted, educational approach is a more effective and equitable means of controlling over-utilization than are penalties, and have the added benefit of preserving quality care.

Physician Self-Referral

We recommend that dispensing eyeglasses and contact lenses by ophthalmologists be exempt from potential self-referral limitations. These are consumer items, for which there is considerable market competition, and dispensing by ophthalmologists contributes importantly to that competition. Dispensing is currently regulated by the

Federal Trade Commission, and various state regulatory agencies, making additional national regulation unnecessary.

National Health Reform

The American Academy of Ophthalmology has adopted a series of principles for national health care. We are also finalizing recommendations for a basic eye health benefit package. We have attached our perspectives for the record.

While we do not endorse any specific proposal at this time, we believe that there are a number of important principles which health care legislation should include:

- * Universal access to quality health care
- * Continuation of a pluralistic financing system with necessary insurance reforms and appropriate patient cost-sharing
- * Patients freedom to go outside of a health care plan to see a physician of their choice and obtain additional services at their expense
- * Medical doctors serving as the managers of the delivery system as well as the providers of the care
- * Coverage of basic benefits including medical and surgical eye care and preventive services, but excluding refractions/eyeglasses except for indigent children
- * Direct access to ophthalmologists for primary (entry level) eye care
- * A sound approach to budgetary accountability within the context of national health care expenditures
- * A reallocation of funds to ensure appropriate expenditures for outcomes assessment, guideline development, and dissemination to assist in their proper use, with active involvement of physician organizations
- * The representation of physicians, including medical specialists, during the development and operation of any new delivery system
- * Malpractice reform
- * Administrative simplification
- * Adequate funding for physician training.

Summary

In summary, we recommend that Congress maintain the current Medicare Fee Schedule formula for calculating practice expenses. We further recommend repealing the "five percent" rule on assistants-at-surgery, and allow payment for assisting surgeons without fee-splitting.

Finally, we present our principles for national health care as an indication of our interest in being active participants in this important debate.

Thank you for the opportunity to express our views.

ATTACHMENT A

Comparison of Top 20 Ophthalmic Procedures
Estimated Average Medicare Fee Schedule
Amounts for 1996 and Estimated Amounts if Practice Expenses
Calculated on a "Resource-Based Model"

CPT	DESCRIPTION	CURR.'96 FEE SCHED. (Est.)	POSS.'96 FEE SCHED. (Est.)	DIFFER.	% CHANGE
65730	Corneal Transplant	\$1236	\$735	-\$503	41%
65750	Trans. in Aphakia	1288	767	-521	40
65855	Laser Trabec.	500	288	-212	42
66170	Trabeculectomy	789	703	-86	11
66625	Peripheral Irid.	481	320	-161	33
66761	Laser Iridotomy	439	224	-215	49
66821	YAG Capsulotomy	327	159	-168	51
66930	Removal of Lens Lesion	520	479	-41	8
66983	Intracap. Catar. with IOL	895	543	-352	39
66984	Extracap. Catar. with IOL	942	607	-335	36
66985	Secondary Implant	679	479	-200	29
67005	Partial Vitrectomy	948	415	-533	56
67010	Partial Vitrectomy- Mechanical	903	415	-488	54
67036	Vitrectomy, pars plana	1357	703	-654	48
67107	Scleral buckling	1177	863	-314	27
67210	Laser, focal	621	575	-46	7

CPT	DESCRIPTION	CURR.'96 FEE SCHED. (Est.)	POSS.'96 FEE SCHED. (Est.)	DIFFER. %	CHANGE
67228	Laser PRP	728	767	+ 39	+5
67904	Ptosis resection	611	383	-228	37
67917	Blepharoplasty, extensive	469	351	-118	25
67924	Blepharoplasty, wheeler	459	351	-108	24

**American Academy of Ophthalmology
Perspectives on Health Care Reform
1993**

Introduction

The American Academy of Ophthalmology believes that significant changes are needed to ensure access to quality health care for all Americans. The Academy welcomes the opportunity to join with others to help fashion effective changes that will address critical health care reform issues as well as promote the delivery of quality eye care to all Americans.

All of the comprehensive reform proposals that have been offered to date involve complex tradeoffs that will have important effects on physician-patient relationships. Ophthalmologists continue to seek solutions that protect the welfare of their patients.

Current proposals that have been introduced as Congressional legislation do not directly address many of the important questions that will need to be resolved in order to determine the actual impact of such proposed reforms on the delivery of eye care in the United States. For this reason, the Academy has elected not to endorse any specific legislative proposal at present.

The Academy does believe that there are a number of important principles which upcoming reform legislation should include:

- * *Universal access to quality health care*
- * *Continuation of a pluralistic financing system with necessary insurance reforms and appropriate patient cost-sharing*
- * *Patient freedom to go outside of a health care plan to see a physician of their choice and obtain additional services at their expense*
- * *Medical doctors serving as the managers of the delivery system as well as the providers of the care*
- * *Coverage of basic benefits including medical and surgical eye care and preventive services, but excluding refractions/eyeglasses except for indigent children*

- * *Direct access to ophthalmologists for entry level eye care*
- * *A sound approach to budgetary accountability within the context of national health care expenditures*
- * *A reallocation of funds to ensure appropriate expenditures for outcomes assessment, guideline development, and dissemination to assist in their proper use, with active involvement of physician organizations*
- * *The representation of physicians, including medical specialists, during the development and operation of any new delivery system*
- * *Malpractice reform*
- * *Administrative simplification*
- * *Adequate funding for physician training*

Access to Care

Any credible proposal for health care reform must embody a concrete plan to ensure timely access of every American to quality health care services. If reform proceeds toward universal access in a defined series of incremental steps, ophthalmologists will continue to honor their professional responsibility to ensure that necessary care is rendered to their patients without regard to the ability to pay.

The Academy is already a leader in providing important eye care services for those who may have otherwise gone without. The National Eye Care Project (NECP), a public service program sponsored by the state ophthalmological societies and the Academy, has worked to reduce the number of blinding eye diseases which occur in the 65 and older population — the segment of the population in which 50 percent of new cases of blindness will develop each year. Through an NECP network of over 7,400 volunteer physicians, eligible seniors have been provided comprehensive medical examinations of the eye at no cost.

Similarly, through the National Eye Health Education Program (NEHEP), the Academy, working in partnership with the National Eye Institute (NEI) and other private and public organizations, has targeted high risk groups for eye health education programs which encourage early detection and timely treatment of glaucoma — the leading cause of blindness in older adults and African Americans over the age of 40 — and diabetic eye disease — eye complications that threaten the eyesight of 14 million Americans with diabetes.

The Academy recommends its NECP program and endorses the NEHEP as models suitable for use by other medical organizations.

Notwithstanding, the Academy believes that true reform must embody universal access to care as a minimum criterion for "success". Such access must be accompanied by a fair system that provides equitable compensation for services rendered.

Insurance reforms should include the elimination of barriers to coverage such as pre-existing conditions, experience rating, and other mechanisms that limit access, especially to small groups. Individuals should have "portable" insurance coverage that is not tied to a specific employer, and the employees should have a choice of health plans as well as providers.

The Objectives of the Health Care Financing System

All reform proposals presently being considered imply significant changes in the structure of the Nation's current public and private health care financing systems. The Academy supports continuation of a pluralistic financing system which reflects the diversity of patient need and geographic distribution. Such a system could incorporate competitive managed care plans.

In recent years, private insurance markets have acted to exclude from insurance coverage many who need care most. And the proliferation of competing private insurance and utilization review systems has created confusing, costly and contradictory administrative and paperwork requirements through which physicians must pass in order to provide needed care.

For these reasons, the Academy does not believe that reforms based on continuation of a pluralistic financing system can succeed unless they are accompanied by reforms that eliminate competition by risk selection, reduce the proliferation of health plans and of competing standards of care, and simplify administrative requirements.

Federal involvement may set insurance parameters, limit the number of competing plans and define a basic benefit package in order to assure universal access, but patients should have the freedom to purchase supplemental coverage, and to go "outside" of their plan to see the physician of their choice and/or to seek additional services at their own expense.

The Scope of Health and Eye Care Benefits

The American public expects and deserves appropriate, qualified medical care. The Academy believes that entry level care of the eye should be viewed similarly to primary medical care of any other organ systems of the body. Ophthalmologists are medically trained physicians who are available and uniquely qualified to provide this care to the public. All health plans should provide patients with access to an ophthalmologist as a primary care provider or an ophthalmologist as a direct supervisor of their primary eye care.

The Academy believes that a reasonable starting point for eye care benefits includes:

necessary medical and surgical eye care, including consultant and referral services, inpatient and outpatient hospital and other necessary ambulatory facility services, diagnostic eye services and tests, diagnostic laboratory and diagnostic and therapeutic radiologic services, emergency health services, and eye examinations to determine the need for visual correction for indigent children.

Basic benefits should include access to necessary primary as well as subspecialty eye care.

The American Academy of Ophthalmology has adopted recommendations for a minimum preventive eye care package (attached) that should be included in a basic benefit plan.

Preventive eye care should also include employer responsibility to cover the cost of job-related eye protection (goggles, and other protective items required by OSHA, etc.).

To the extent that benefits would be provided under network-based delivery systems that feature restrictions on referral to professional services, the Academy is strongly opposed to restrictions that would deny patients direct access to ophthalmologists for entry level eye care services. Ophthalmologists are the only professionals trained to manage, treat and appropriately refer patients with vision care problems and eye diseases. The Academy recognizes that there may be a need to integrate the provision of eye care with other professionals such as optometrists.

In light of the prohibitive cost, adult eyeglasses or cosmetic contact lenses should not be part of a basic plan, but might be offered as a supplemental option.

Mechanisms to Control the Rate of Growth of Health Care Costs

Ophthalmology is prepared to work with government and private entities in developing an effective strategy for cost-containment which ensures the availability of quality, cost-effective care that is based on the needs of the patient and the judgement of the physician. In particular, the Academy believes that efforts should focus on patient education, preventive care, the evaluation of new technologies, the reassessment of old technologies and the development of multidisciplinary teams to provide integrated care.

The Academy is concerned about the potential negative effects of 'global' health budgets that are arbitrarily devised and not based on the recognition of new technologies, growth of population segments requiring special care i.e. elderly, additional government mandates and requirements and uncontrollable factors such as epidemics.

Current proposals appear to assume that the "right" amount of national spending for health care can be determined. It is possible that such global budgeting schemes could reduce quality patient care by severely reducing incentives for technological advances, could accelerate the closing of vulnerable urban and rural health care facilities and could reduce access through longer waits for services or other forms of rationing. Moreover, such budgets, when inappropriately linked with so-called gatekeepers, could act to limit patient access to needed specialized care.

For similar reasons, the Academy does not support regulatory measures that would tie health spending to arbitrary standards, such as a designated percentage of the GNP, unrelated to the true cost of providing needed care to our citizens.

The Academy believes that the cost of health care is driven by the underlying cost of the scope and volume of services rendered to patients. In many cases, the base of knowledge about the clinical efficacy and cost effectiveness of diagnostic and therapeutic alternatives is less than optimal and may result in an escalation in the cost of care.

For this reason, the Federal government's central role in basic biomedical research should continue and should include assessment of the relative clinical efficacy and potential cost effectiveness of new modalities of care generated from basic research. Such research should be complemented by funding for outcomes assessment and guidelines development with respect to present clinical practices.

In addition to fostering such research, the Federal government should take a leading role in the development and operation of mechanisms to promote dissemination of research findings among clinical practitioners. The Academy believes strongly,

however, that the ultimate responsibility for the evaluation of scientific and clinical issues in medicine rests with the professional medical societies. The Academy has taken a pro-active role in this arena by developing a series of Preferred Practice Patterns for key ophthalmic clinical entities.

At the same time, many factors in society outside the direct control of physicians -- from patient lifestyles and administrative burdens to the legal environment in which medicine is practiced -- needlessly increase the nature and scope of care provided. The Academy believes that the cost containment approaches embodied in health care reform must concentrate on addressing these underlying determinants of cost. Issues regarding first dollar coverage, cost-sharing, and means-testing should also be examined.

The Academy recognizes that creating a health care financing system that will contain costs may produce significant changes in the economic organization of medicine -- including changes that many physicians and patients may find unwelcome. To the extent that proposals for reform involve increased economic regulation by public bodies or private health plans, the Academy believes that designers of such schemes should be mindful of the consequences of different approaches on the availability of quality eye care.

Should national or regional governing boards be developed to address such issues as cost containment, guidelines development or utilization review, direct representation of physicians, including medical specialties, must be assured. The Academy believes that such representation should at minimum reflect a diversity in medical specialties and professional practice, i.e. solo practitioners, group practitioners, academicians as well as a minimum level of recent professional involvement in patient care.

It is essential that managed care systems maintain a primary role for physicians in the clinical management of patients. The fundamental driving force in any health care system should be the patient's health care needs and the maintenance of the physician-patient relationship in order to assure that patient needs are met in a timely manner.

The Federal government also should take immediate action to relieve our health care system of the unnecessary costs generated by excessive malpractice litigation. The Academy strongly supports reform measures advocated by the American Medical Association to alleviate this crisis.

All private and public plans, including the Medicare program, should be required to contribute toward underwriting the cost of graduate medical training since everyone will benefit from maintaining quality training programs.

In summary, the Academy believes that "cost containment" is not an end in itself, but rather a means by which we as a society can ensure universal access of our citizens to quality health care, including medical, surgical and preventive eye care.

The Academy is hopeful that if reforms are adopted that give the American people confidence that their resources are being well spent, we as a Nation will be willing to spend what is needed to assure access to quality professional eye care for all of our citizens.

Developed by the Federal Economic Policy Committee, 12/92

Approved by the Secretariat for Federal Affairs, 1/16/93

Approved by the Board of Trustees, 2/20/93

Attachment: Priorities of the American Academy of Ophthalmology's
Preventive Eye Care Package

**Priorities of the American Academy of
Ophthalmology
Preventive Eye Care Package**

Diabetic Retinopathy

Patients with diabetes are at high risk for developing diabetic retinopathy, a proliferation of blood vessels in the eye which causes blindness if not diagnosed and treated early in the progression of the condition, therefore:

Patients with juvenile diabetes (Type I) should begin an annual comprehensive eye exam within five years after onset, and;

Patients with adult onset diabetes (Type II) should have a comprehensive eye exam at the time of diagnosis and on an annual basis thereafter.

Glaucoma

Glaucoma, elevated intraocular pressure that damages the optic nerve causing blindness, if detected early, can be treated to arrest or to minimize the loss of sight; therefore:

African Americans, who are at higher risk for developing glaucoma, with onset of optic nerve damage at an earlier age and more severe damage at the time of detection, should receive:

Between the ages of 20–39 years a comprehensive eye evaluation with attention to measurement of optic nerve status and intraocular pressure every 3–5 years.

Between the ages of 40–64 years a comprehensive eye evaluation with attention to measurement of optic nerve status and intraocular pressure at appropriate intervals.

All others should receive a comprehensive eye exam at appropriate intervals, which will depend on their age, family history, presence of systemic disease or other risk factors for glaucoma.

Eye Screening for Children

Children are susceptible to many correctable eye conditions such as strabismus, amblyopia (lazy eye) and refractive errors. Detection of these conditions in the preschool age child allows for proper correction of these conditions that, if left uncorrected for even a few years, can permanently affect a person's ability to see, therefore:

All children should have vision exams prior to entering school, preferably at approximately 3 and 5 years of age.

* These are considered minimal recommendations for preventive eye care: please refer to the Academy's comprehensive preventive eye care services package for complete information.

Chairman STARK. Thank you, Dr. Jensen.
Dr. Wallace.

STATEMENT OF K.K. WALLACE, M.D., CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY; ACCOMPANIED BY JAMES MOREFIELD, M.D., PRESIDENT

Dr. WALLACE. Thank you, Mr. Chairman.

My name is K.K. Wallace. I am a radiologist from Charlottesville, Va. I serve as chairman of the board of chancellors of the American College of Radiology.

With me today also is Dr. James Morefield of Sacramento, who is the president of the American College of Radiology.

I am pleased to present the following testimony related to the 1994 Medicare budget.

The ACR is concerned that the administration's 1994 budget deficit proposals are ill-conceived and fail to address the problems that administration claims are inherent in the Medicare payment system.

The most egregious proposal in the budget would bundle payments for radiology, anesthesiology, and pathology into single payments based on diagnosis-related groups. We are surprised that the administration has chosen this failed proposal from a previous administration to include in the current budget.

The Congress has rejected this notion on several occasions, including proposals in 1965, 1972, and 1987. After your deliberation of the RAPs idea in 1987, you adopted a provision in the law that specifically prohibits implementing such a system. We strongly urge you to reject this proposal for the fourth time.

The administration claims the justification for the RAPs DRG proposal is overutilization and increased utilization of radiology services in the inpatient hospital setting, and it attributes the increase to radiologists. This contention ignores the facts.

Data from the Health Care Financing Administration shows that the extraordinary increase in the volume of services in radiology in the inpatient hospital setting is not attributable to radiologists, but to nonradiologists performing radiology services. Virtually all radio-

logical procedures performed by radiologists are ordered by referring physicians.

The larger increases in radiology services have taken place in the outpatient and office settings. Further, we note that the increase in utilization of radiology services has occurred because of the incidence of self-referral by nonradiologists for diagnostic testing and treatment.

We are pleased that you have recognized an important facet of the self-referral problem and have attempted to pass legislation which would bar physician referrals to facilities in which they have ownership interest. For almost a decade, the ACR has raised this issue, and we are pleased that recognition of this program has now garnered almost universal acceptance. But this is only part of the problem.

Based upon Medicare data and peer-reviewed studies, we find that the growth in self-referral by nonradiologists has been substantial. We believe that medicine and the Congress must address this utilization problem which has significant budget implications.

Where there is inappropriate utilization, we stand ready to define a system to eliminate it. Work has begun on such a system. To complete this work, we are willing to expend the same efforts and resources as we did in developing a fee schedule for Medicare payment.

We believe we are uniquely positioned in the health care delivery system to develop patient care guidelines for diagnostic imaging and therapeutic radiology. Because of our consultative role in medicine, we see patients only on referral, and therefore conflict of interest is avoided.

One way to address this problem is through the development of diagnostic patient care guidelines. These guidelines would identify what procedures are most beneficial to patients. The guidelines could also identify which procedures might be more cost-effective.

We believe that such guidelines would produce significant savings in the health care system with no negative impact on the quality of care given patients. We also believe that such a system would provide the most appropriate care by physicians who are best trained to provide the care.

It is essential that any system of patient care guidelines be unambiguous, so there can be easy compliance and monitoring.

If such a system of guidelines is to be effective, there must be meaningful reform of the professional liability environment. Many States have adopted changes in their laws to reform professional liability, and we urge the Congress to consider assisting this effort.

We also urge you to adopt changes in the fraud and abuse laws, which will make enforcement of these laws easier and more meaningful, and we support the chairman's legislation which would accomplish this.

The ACR believes that these ideas are realistic recommendations to deal with the problems of cost and overutilization of radiology services. Simply bundling RAP payments does nothing to address the issues of inappropriate utilization of services, nor does it provide any safeguard to assure patients have access to the most appropriate care.

The ACR has a proven track record of working with this subcommittee, the Congress, and the Health Care Financing Administration to develop meaningful changes in the physician payment system.

We look happy to working with the Congress and the Administration to address concerns with the health care system. We will be happy to supply data concerning our ideas for your review. Our proposals will address your deficit reduction goals in a more appropriate way than those submitted by the administration.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of the
American College of Radiology
before
the Subcommittee on Health
U.S. House of Representatives Ways and Means Committee
March 25, 1993

The American College of Radiology is pleased to present the following testimony for the record of the Ways and Means Committee Subcommittee on Health on issues related to the 1994 Medicare Budget.

The Administration's budget for federal fiscal year 1994 contains recommendations for further significant reductions in federal spending for Medicare. The ACR is concerned that these deficit reduction proposals are ill-conceived and fail to address the problems the administration claims are inherent in the Medicare payment system. The budget proposals ignore the tremendous efforts of medical groups, such as the ACR, who have worked in good faith with the Congress to address cost and payment concerns with the Medicare program.

The ACR has a proven track record of working with this subcommittee, the Congress and the Health Care Financing Administration to develop meaningful changes to the physician payment system. We expended tremendous efforts and resources to develop a fee schedule and a methodology for appropriate changes and modifications to it. We are pleased to note that much of our methodology for updating relative values was incorporated by the American Medical Association in its system for reviewing relative values and we are pleased to participate with the rest of medicine in that process.

The Administration now proposes to ignore these sincere efforts on the part of medicine. We believe the budget recommendations would have the effect of canceling our collective efforts to reform the physician payment system. Further, we believe that these recommendations are premature. Based on the most current data on volume performance standards, there seems to be a moderation in increases in physician payments in the Medicare program.

The most egregious proposal in the budget recommendations is that which again recommends bundling payments for radiology, anesthesiology and pathology into single payments based on diagnosis-related groups. We are surprised that the Administration has chosen this failed ill-conceived proposal from the previous Administration to include in its current Medicare budget recommendations.

The Congress has rejected this notion on several occasions including proposals in 1965, 1972 and 1987. After your deliberation of the RAPs idea in 1987, you adopted a provision in the law that specifically prohibits implementing such a system. We strongly urge you to reject this proposal for the fourth time.

The Administration claims the justification for the RAPs DRG proposal is over-utilization and increased utilization of radiology services in the in-patient hospital setting and attributes the increase to radiologists. This contention ignores the facts. Data from the Health Care Financing Administration shows that extraordinary increases in volume of services in radiology in the in-patient hospital setting is not attributable to radiologists, but to non-radiologists performing radiology services. Virtually all radiological procedures performed by radiologists are ordered by referring physicians. Secondly, the larger increases in radiology services have taken place in the out-patient and office setting. Further, we note that the increase in utilization of radiology services has occurred because of the incidence of self-referral by non-radiologists for diagnostic testing and treatment.

We are pleased that the chairman of the subcommittee has recognized an important facet of the self-referral problem and for several years has attempted to pass legislation which would bar physician referrals to facilities in which they have ownership interest. For almost a decade, the ACR has raised this issue and we are pleased that recognition of this problem has now garnered almost universal acceptance. The ACR is pleased to have played a role

in the AMA's adoption of a policy statement which addressed the abuse of these self-referral arrangements. We hope that 1993 will be the year that the chairman is successful in securing passage of legislation addressing joint venture self-referral. But, this is only a part of the problem.

Based on Medicare data and peer-reviewed studies, we find that joint venture self-referral is only a small portion of the self-referral problem. The growth of self-referral by non-radiologists has been substantial. We believe that medicine and the Congress must address this utilization problem which would result in significant budget savings.

Where there is inappropriate utilization, we stand ready to define a system to eliminate it. Work has begun on such a system. To complete this work, we are willing to expend the same efforts and resources as we did in developing a fee schedule for Medicare payment. We believe we are uniquely positioned in the health care delivery system to develop patient care guidelines for diagnostic imaging and therapeutic radiology. Because of our consultative role in medicine, we take patients on referral and therefore conflict of interest is avoided.

One way to address this problem is through the development of diagnostic patient care guidelines. These guidelines would identify what procedures are most beneficial to patients. Guidelines also could identify which procedures are most cost-effective. We believe such guidelines would produce significant savings in the health care system with no impact on the quality of care given patients. We also believe that such a system would provide for the most appropriate care by physicians who are best trained to provide the care. It is essential that the system of patient care guidelines be unambiguous so there can be easy compliance and monitoring.

There must also be meaningful reform of the professional liability environment if guidelines are to work. Many states have adopted changes in the law to reform professional liability and we urge the Congress to do the same. We also urge you to adopt changes in the fraud and abuse laws which will make enforcement of these laws easier and more meaningful, and we support the chairman's efforts in this regard.

The ACR believes these ideas are realistic recommendations to deal with problems of cost and over-utilization of radiology services. Simply bundling RAP payments does nothing to address the issues of inappropriate utilization of services nor does it provide any safeguards to assure patients have access to the most appropriate care.

Our second major concern with the President's budget proposals is the recommendation to arbitrarily change the updates for Medicare physician payment. The RBRVS fee schedule was adopted to correct perceived inequities in physician payment. We believe it is inappropriate to change the system of updates which would effectively change the basis of a fee schedule that is not fully implemented and is still in the process of refinement.

The Congress, the previous administration and the medical community expended considerable time, money and effort working together to develop a payment system for physicians that addressed perceived inequities in payment among physicians and among different localities across the country. Even though this fee schedule is only half way through the process of implementation, several proposals from the administration involve changes which would completely destroy the basis of the fee schedule.

There are lingering problems with the Medicare fee schedule including the previous administration's contention of a behavioral offset in response to changes in payments. We recommend fixing the remaining problems with the fee schedule rather than throwing it out and starting over.

The ACR's third concern with the budget proposal is related to funding for training physicians. We believe it is inappropriate to arbitrarily decide that funding for training specialists should be reduced. The need for specific specialists should be based on need and not perception. Changing the supply of specific specialties is not a panacea for eliminating inappropriate utilization of medical services. It is more appropriate to determine need for services and provide sufficient numbers of specialists to meet those needs. This will also allow for provision of the most appropriate care by the best qualified physician.

In addition to the specific problems we have with the Administration's budget proposals, there is a general observation to make regarding Medicare budget

considerations. We question the appropriateness of discussing recommendations for policy changes in the Medicare program when the administration has not yet completed its work on the anticipated plan for reform of the health care delivery system. Some of the President's budget proposals raise policy issues that may be incongruent with proposals for health care system reform.

We will be happy to supply data concerning our ideas for your review. Our proposals will address your deficit reduction goals in a more appropriate way than those submitted by the administration.

As we have in the past, the ACR looks forward to working with the Congress and the administration to address concerns with the health care system.

Chairman STARK. Thank you very much.
Dr. McDermott.

STATEMENT OF PETER L. McDERMOTT, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Dr. PETER McDERMOTT. Thank you, Mr. Chairman.

I am Peter McDermott, an anesthesiologist in private practice in Camarillo, Calif., and I appreciate the opportunity to be here today.

For reasons we cannot understand, the Clinton budget has borrowed a page from a Reagan budget and proposed to bundle payments for inpatient radiology, anesthesiology, and pathology services into the hospital DRG payment. This proposal was rejected by the Congress in 1987 and is at total odds with the underlying concepts of the Medicare fee schedule more recently mandated by Congress.

The ASA has worked with this subcommittee over the years to achieve significant budget savings. We have been realistic in our assessment of the need for Congress to find appropriate savings without adversely affecting the quality of anesthesia care. This has meant reductions in Medicare payments to our members which average about 40 percent over the last few years.

In part, at least, our good-faith cooperation with the Congress in achieving deficit reduction has stemmed from the continuing commitment of this subcommittee and the full committee to the methodology for anesthesia reimbursement advocated by ASA; that is, the use of a relative value guide in which both the procedural and time units are recognized.

One of the reasons that Congress decisively rejected RAP DRGs in 1987 was the anticipation of development and implementation of a Medicare fee schedule. A series of legislative actions defined treatment of anesthesia services under the fee schedule, indicating a Congressional intent that could not be more different than the RAP DRG proposal.

OBRA 1987, which rejected RAP DRGs, mandated that HCFA adopt a uniform relative value guide for use by all Medicare carriers. HCFA subsequently adopted the ASA relative value guide as that guide.

OBRA 1989 contained a significant policy change regarding anesthesia time, a change put forward by this subcommittee as a way to achieve accuracy of reimbursement. ASA supported this sound approach, and anesthesia time is now recognized in terms of actual minutes.

Most importantly, OBRA 1989 also addressed anesthesia services with regard to their integration into the Medicare fee schedule and instructed the Secretary to use the uniform relative value guide, which uses procedural and time units for anesthesia services.

ASA and our members are well aware that this subcommittee and Chairman Stark were instrumental in persuading HCFA not to eliminate anesthesia time units, which would have been contrary to the express will of Congress, when the fee schedule was put into effect. H.R. 21, introduced this year, reinforces the Congressional commitment to preserve actual anesthesia time.

According to the HHS budget, RAP DRGs would give "physicians and hospitals incentives to be cost-conscious, provide only medically-necessary services, and eliminate the provision of marginal services."

This rationale is seriously flawed. Clearly there is no such thing as a marginal anesthetic. There is no marginal service in the pre-operative evaluation and selection from potentially lethal anesthetic agents of the appropriate anesthesia care plan for an individual patient. There is no marginal service intraoperatively when the anesthesiologist manages the patient in a carefully controlled anesthetized state at a medically-determined level between consciousness and death for a period of time dictated by the surgeon and not by us. Nor is there marginal service postoperatively when we manage restoration of the patient's respiratory and cardiovascular systems to normal.

ASA believes that the RAP DRG proposal will severely interfere with our direct relationship with patients. The administration proposal will place a third party, the hospital or entity within the hospital, between the anesthesiologist and his or her patient. This concern was echoed in a Congressional Research Service paper in 1986 which stated that RAP DRGs could compromise the physician's role as patient advocate. These are valid concerns, because DRGs do not pay for services actually provided; in fact, they reward the hospital for services not provided.

Finally, ASA's opposition also stems from our deep concern that hospital DRGs do not describe or measure anesthesia services provided to our patients. DRGs were not designed to account for physician services, and they cannot.

The anesthesiologist's relationship with their patients is exactly the same as that of the surgeon. There is a preoperative exam and evaluation, an intense relationship during surgery itself and post-operative care. It is simply incredible that the administration would seek to treat similar disciplines so incongruously and so unfairly.

We do not ask for special treatment. If anything, the history of budget cuts shows anesthesiologists have had far more than their fair share of special treatment. We ask to be treated like all other physicians.

There should be no differential updates. If the Congress considers a limited MEI update or freeze for all physician services, then that is the appropriate place to address anesthesia services. We ask you to forcefully reject RAP DRGs, and we ask for your continued support of anesthesia time.

We have not addressed the PPRC's proposal on payment reductions to the anesthesia care team in this statement, but we will submit an additional statement, and I would be prepared to answer questions on that issue as well.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF PETER L. McDERMOTT, M.D.
American Society of Anesthesiologists

Mr. Chairman, I am Peter L. McDermott, M.D., President of the American Society of Anesthesiologists (ASA), which represents more than 30,000 physicians nationwide. I am in the private practice of anesthesiology in Camarillo, California. I am pleased to be here today to discuss the so-called "RAP DRG" proposal in the Administration's Fiscal Year 1994 budget.

For reasons we cannot understand, the Clinton budget has borrowed an unsuccessful page from the FY88 Reagan budget and proposes to bundle payments for inpatient radiology, anesthesiology and pathology services into the Part A hospital DRG payment. This proposal was a bad idea when the Congress rejected it in 1987. Subsequent enactment of the Medicare Fee Schedule makes it a worse idea today. The projected four year savings are \$390 million - a relatively modest sum to offer as justification for so radical a proposal; indeed, a proposal at total odds with the underlying concepts of the Medicare Fee Schedule mandated by Congress.

The ASA has worked with this Subcommittee over the past several years to achieve significant budget savings. We certainly never welcomed reimbursement reductions but we have been realistic in our assessment of the need for the Congress to find appropriate savings without adversely affecting the quality of anesthesia care. Given this background, we find the Administration's proposal both inappropriate and insensitive: inappropriate because it comes hard on the heels of implementation of the Medicare Fee Schedule under which the specialty of anesthesiology sustained the largest cut of any specialty, and insensitive to legitimate quality of care concerns and to the nature of anesthesiology practice.

To put the RAP DRG proposal in budgetary context, allow me briefly to review the recent history of Medicare reductions for our specialty:

- OBRA '86 ratified HCFA regulations halving the base units for cataract anesthesia services from 8 units to 4 units. Estimated five year savings were \$405 million.

- OBRA '87 mandated base unit reductions for those anesthesiologists (70 percent of anesthesiologists) medically directing nurse anesthetists. Estimated three year savings were \$35 million.

- OBRA '89 froze anesthesia reimbursement rates and mandated the use of actual anesthesia time, as opposed to rounding up to the next whole unit. Estimated five year savings were \$245 million.

- OBRA '90 cut the average anesthesia conversion factor by 7 percent and extended the base unit reductions for medical direction services. Estimated five year savings were \$285 million.

- The Medicare Fee Schedule, effective January 1, 1992, reduced reimbursement for anesthesia operating room services an average 29 percent upon full implementation -- the largest cut imposed on any specialty.

- 1993 Fee Schedule reduced all physician services another 2.7 percent to achieve budget neutrality for new and revised codes.

In the aggregate, these are dramatic reductions to be placed on one specialty, but to a great extent they have occurred as a result of active good faith give-and-take between ASA representatives and the health committees of the Congress. In part, at least, our cooperation with otherwise unpleasant reimbursement decisions has stemmed from the continuing commitment of the Congress, including this Subcommittee and the full Committee, to the methodology for anesthesia reimbursement advocated by ASA; that is, the use of a relative value guide in which both the procedural and time units are recognized to determine the value of a specific physician service to specific patient.

MEDICARE FEE SCHEDULE AND ANESTHESIA REIMBURSEMENT

One of the reasons Congress decisively rejected RAP DRGs in 1987 was the anticipation of development and implementation of a Medicare Fee Schedule (MFS) based on the Resource Based Relative Value Scale (RBRVS). Many experts, such as the Physician Payment Review Commission, believed that any problems with RAP services would best be addressed through modification of fee-for-service payment for these services.

In the years since 1987, these modifications have occurred via several legislative and regulatory actions which built upon one another and confirmed the commitment of Congress to reimbursing anesthesia services under the Medicare Fee Schedule, using the ASA Relative Value Guide (RVG), and addressing perceived problems with payment levels.

The Omnibus Budget Reconciliation Act of 1987

OBRA '87, which rejected RAP DRGs, mandated that the Health Care Financing Administration (HCFA) adopt a Uniform Relative Value Guide (URVG) for use by all Medicare carriers. Pursuant to notice and comment in the Federal Register, HCFA adopted the ASA RVG as the URVG, for services provided on or after March 1, 1989. An important corollary to this was the adoption of the CPT-4 anesthesia codes, in lieu of surgical codes previously required on claims. The 4200 surgical codes are successfully complemented by only 248 broad anesthesia codes because the addition of anesthesia time measures the difference -- from the anesthetic standpoint -- between the many thousand surgical procedures. I must repeat the specific consideration of actual anesthesia time, makes the use of anesthesia codes valid.

Omnibus Budget Reconciliation Act of 1989

Prior to the OBRA '89, anesthesia time was counted and reimbursed in terms of 15 or 30 minute units, with the actual time rounded up to the next whole unit. OBRA '89 contained a significant policy change regarding recognition of anesthesia time -- a change proposed by the Inspector General as a way to achieve accuracy of reimbursement; ASA supported this sound policy approach. Anesthesia time is now recognized in terms of actual minutes or fractional units. This not only achieved budget savings for the Program, but brought tighter verification to anesthesia time.

Most importantly, OBRA '89 also addressed anesthesia services with regard to their integration into the Medicare Fee Schedule. Section 1848(b)(2)(B) of the Social Security Act therefore states:

In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustments in the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value.

From our perspective, this statutory requirement for the Department of Health and Human Services to use the Uniform Relative Value Guide for anesthesia services -- in essence, the ASA Relative Value Guide utilizing both base and time units -- is one of the most critical elements of OBRA '89. ASA and our members are well aware that this Subcommittee and Chairman Stark were instrumental in persuading HCFA not to eliminate anesthesia time units, which would have been contrary to the expressed will of Congress, when the final Medicare Fee Schedule was put into effect. H.R. 21, introduced this year by Chairman Stark and Chairman Rostenkowski, reinforces the Congressional commitment to preserving actual anesthesia time.

ASA believes the intent of Congress is both clear and consistent: the Uniform Relative Value Guide, including base units plus actual time, should be the basis for reimbursing anesthesia services under Medicare. With ASA's involvement and support, the Congress over the years has painstakingly crafted its policy on anesthesia reimbursement as part of physician payment reform -- and the Administration's DRG proposal is totally contradictory to that policy. (There would, obviously, be no more RVG or anesthesia time under a RAP DRG scheme.)

THE ADMINISTRATION PROPOSAL HAS FLAWED RATIONALE

According to the Department of Health and Human Services (DHHS) budget, RAP DRGs would give "physicians and hospitals incentives to be cost-conscious, provide only medically necessary services and eliminate the provision of marginal services."

This rationale is seriously flawed. First, and I hope this is self-evident to the Subcommittee, there is no such thing as a "marginal" anesthetic. There is no "marginal service" in the pre-operative evaluation of patients and in the selection, from an array of potentially lethal anesthetic agents, of the appropriate anesthesia plan for an individual patient. There is no marginal service intraoperatively, when the anesthesiologist manages the patient in a carefully controlled anesthetized state, at a medically-determined level between consciousness and death, for a period of time dictated by the surgeon, not by us. Nor is there a "marginal service" post-operatively, when we manage restoration of the patient's respiratory and cardiovascular systems to normal.

Second, the Administration's rationale is inconsistent with demonstrated experience with reimbursement for anesthesia services. A recent study analyzed changes in Part B expenditures between 1986 and 1989 and was published in the Journal of the American Medical Association (JAMA, Holahan and Berenson, 1992). While anesthesia accounted for approximately 6 percent of Part B expenditures, it represented only 2.6 percent of the growth in expenditures. Over the same period, the average annual growth in allowed charges for anesthesiologists was 7.7%, against 12.3% for all physicians.

This data shows only the effects of the fee freeze, OBRA '86 and OBRA '87; the significant impact of the OBRA '90/Medicare Fee Schedule combined 38.7 [average] percent reduction is not even measured at this point. This data also underscores the inability of anesthesiologists to increase volume, or introduce "marginal" services, in response to payment reductions per service.

Concerns stated in earlier years about this specialty -- particularly concerns with low participation rates and significant balance bills -- have been addressed with implementation of the series of reimbursement reductions and imposition of strict balance billing limits. While only one fifth of anesthesiologists accepted Medicare Participating Physician status in 1987 (more than 10 percent below the national average), as of January 1992, nearly one half of anesthesiologists were Participating doctors (less than 3 percent below the national average.) We have every reason to believe that the 1993 participation and assignment rates are even higher. For those who choose not to accept assignment on a given case, the Medicare Fee Schedule allows a balance bill of somewhat less than 10 percent.

Third, to the extent the rationale for RAP DRGs is based on allegedly unnecessary anesthesia procedures, it simply ignores the mechanisms within its own Department which deal with medical necessity issues -- mechanisms which neither HCFA nor the Inspector General are reluctant to use.

RAP DRGs WOULD IMPACT QUALITY OF CARE

ASA believes that the RAP DRG proposal will severely interfere with our direct relationship with patients. The administration proposal will place a third party -- the hospital or entity within the hospital -- between the anesthesiologist and his or her patient. This same concern was cited in a Congressional Research Service paper prepared for the Senate Finance Committee in 1986: "Implementation of a physician DRG system would too closely align the incentives of physicians with hospitals. This might well result in the physician not continuing to be as strong an advocate for needed medical services..." These are valid concerns because DRGs do not pay for services actually provided; in fact, they reward the hospital for services not provided. The hospital incentive will be to limit needed care or to avoid very ill patients in need of surgery.

Even if we lay aside our grave quality of care concerns about such a system, we are deeply disturbed by the concept that we would be providing our service not to the patient, but to the hospital. Anesthesiologists have been practicing as fee-for-service physicians since long before the Medicare Program. While some anesthesiologists may practice under a contractual arrangement with one or more hospitals, these are contracts to assure 24-hour provision of quality services, they are not salary contracts.

Further, the proposal can only address inpatient services. Anesthesiologists provide half their care to outpatients -- what is the rationale for applying two radically different reimbursement mechanisms to services provided in the same operating rooms, but sometimes to inpatients and other times to ambulatory surgery patients?

DRGs ARE NOT RELEVANT TO PHYSICIAN SERVICES

ASA's opposition to the DRG proposal also stems from our deep concern that hospital DRGs do not describe or measure the anesthesia services provided to patients falling within DRGs. What physician DRGs will inevitably represent is a reimbursement system that seeks to "average" medical care within DRG categories that simply were not constructed to account for that care and which, in any given case, will bear no necessary relationship to the services actually provided to a particular patient by the anesthesiologist or, as far as we are aware, by the radiologist, pathologist or for that matter, by the surgeon.

For example, DRG 110 (vascular procedures) would include anesthesia for procedures that vary widely in anesthetic difficulty, from surgery on vessels in the periphery, to surgery for resection of a thoracic aortic aneurysm. These are very different procedures of great variability in difficulty, complexity and skill -- the resource based inputs. The RVG assigns a value of 5 to 8 base units to the former procedures and 20 to the latter, reflecting the significant resource based differences. There are examples such as this for virtually every DRG.

ASA commissioned the Battelle Medical Technology Assessment and Policy Research Center to study the correlation, or lack thereof, between hospital DRGs and anesthesia services. Battelle examined data from 6,300 surgical cases at ten hospitals of varying size and type in five states (summary attached). The Battelle study found the potential for systematic bias within DRGs, with some anesthesia procedures being systematically underpaid, while others were overpaid. Any individual anesthesiologist has neither the volume of cases or control of case mix to mitigate such distortions.

CONCLUSION

The anesthesiologist's relationship with their patients is exactly the same as that of the surgeon: there is a pre-operative exam and evaluation, an intense relationship during the surgery itself, and post-operative care. It is simply incredible that the Administration would seek to treat similar disciplines so incongruously and unfairly.

The ASA cannot speak too strongly against this ill-conceived RAP DRG proposal. If implemented, it would cause serious disruption in patient care, dislocation of physicians and access problems. I can guarantee that physicians would neither stay in, nor enter, anesthesiology as a career if RAP DRGs are approved. This is a critical, demanding specialty with overwhelming implications for patient safety; this cannot be compromised.

We do not ask for special treatment -- if anything, the history of budget cuts shows anesthesiologists have had far more than their share of special treatment. We ask to be treated like all other physicians. There should be no differential updates; if the Congress considers an across-the-board limited MEI update or freeze for all physicians, then that is the appropriate place for anesthesia services. We ask you to forcefully reject RAP DRGs and we ask for your continued support of anesthesia time.

Chairman STARK. Thank you.
Dr. Senhauser.

**STATEMENT OF DONALD A. SENHAUSER, M.D., PRESIDENT,
COLLEGE OF AMERICAN PATHOLOGISTS**

Dr. SENHAUSER. Mr. Chairman, my name is Donald A. Senhauser. I am president of the College of American Pathologists. I am professor of pathology and chairman emeritus at the Ohio State University College of Medicine, and I practice in the Ohio State University Hospitals.

The College appreciates the opportunity to appear before the subcommittee to discuss our perspectives regarding Medicare part B budget reduction proposals.

At the outset, we acknowledge that physicians should be involved in and contribute to the effort to control Federal spending for health care services. The College is willing to work with the subcommittee in that regard.

We are not asking to be exempt from these efforts, but we do ask that pathologists' share of the effort to control health care spending be appropriately structured, that it not be unduly large, given the size of the specialty, and that it not be crafted in such a way that the future of pathology and the quality of laboratory medicine is endangered.

Once again, an administration has proposed bundling Medicare payments for pathology, radiology, and anesthesia services into a fixed payment per discharge.

In 1987, after extensive study and debate, the Congress rejected a virtually identical proposal. We urge you to reaffirm your opposition to this proposal. The College believes that decisions about the relationships between hospitals and pathologists and pathologists and other physicians are best handled at the local level, so that they can be crafted to respond to local health care needs and market conditions.

We believe that the interests of all concerned are best met when payment for physician services is made to the physician who provides those services, without mandated intervention of another party, such as a hospital administration or the medical staff.

The College is willing to work with the subcommittee to discuss a reduced RVS fee schedule update for 1994, as physician's contribution to attempt to reduce health care spending. There is no sound basis for subjecting pathology to a more onerous reduction than is applied to physicians in general.

The College also urges you to allow the RVS practice expense components to go unchanged until more accurate data on what they should be are available.

The budget proposal includes a provision to reduce the national caps on the Medicare clinical laboratory fee schedule, a dramatic reduction that the College must oppose. We are willing to discuss less drastic reductions in payment under the fee schedule, but we would also appreciate the opportunity to work with you to resolve some glaring inequities in payments.

An example is the Pap smear. The Medicare policy for Pap smear testing is truly counterproductive to Federal attempts through the CLIA 1988 regulation to ensure the quality of Pap smears and to

encourage Medicare beneficiaries to avail themselves of this benefit. Payment for the cytotechnologist's screening service was capped in 1992 at \$7.89, well below the cost. In addition, in 1992, HCFA arbitrarily and without opportunity for public comment eliminated separate payment for physician interpretation of outpatient Pap smears, the critical element in the diagnosis of cervical cancer. Problems with the payment policy for Pap smears should be corrected.

Consistent with the American Medical Association policy, the College supports limitations on self-referral. However, we are specifically concerned about exemptions to the prohibitions on self-referral in current bills for interpretation of tissue pathology, Pap smear slides, and cytology services. Prohibitions on self-referral should include these pathology services to assure that there is a level playing field in arrangements for these, our professional services.

In addition, the College firmly believes that a direct billing requirement goes hand in hand with prohibitions on self-referral.

Regarding graduate medical education funding, the College believes that any differential weighting of specialty residency programs should be based on a study of the need for residencies in each specialty, not on an across-the-board reduction in nonprimary care funding.

Mr. Chairman, in closing, I must reiterate that the bundling of pathology services into a payment made to another entity is a counterproductive idea that has been rejected by the Congress previously and should be so again.

We wish to work with the Congress to address the contribution of pathology and laboratory medicine to health care spending reductions, both with regard to the RVS fee schedule and to the clinical laboratory fee schedule. We only ask that we use a surgical scalpel rather than a meat-axe approach to these complex issues.

We thank you for the opportunity to appear here today, and I will be happy to answer any questions.

[The prepared statement and attachments follow:]

**Testimony of the College of American Pathologists Before the Subcommittee on Health,
Committee on Ways and Means, U.S. House of Representatives
on Medicare Part B Budget Issues**

The College of American Pathologists appreciates the opportunity to appear before the Subcommittee on Health to discuss pathologists' perspective relating to Medicare Part B budget proposals. The College represents more than 13,000 physicians who practice laboratory medicine in community hospitals, academic medical centers, independent medical laboratories, and other settings in which Medicare patients are provided necessary medical services.

At the outset, we would like to acknowledge that physicians should be involved in and contribute to the effort to control Federal spending for health care services. The College of American Pathologists is willing to work with the Subcommittee in that regard. We are not asking to be exempt from those efforts. We do ask that pathologists' share of the efforts to control health care spending be appropriately structured, that it not be disproportionately large given the size of the specialty, and that it not be crafted in such a way that the future of pathology and the quality of laboratory medicine will be endangered.

In the Administrations' budget plan are several proposals that would affect pathologists. The College testimony today focuses on six of those items.

I. Bundling Inpatient Pathology, Radiology, and Anesthesia Payments

Once again an Administration has proposed bundling Medicare payments for pathology, radiology, and anesthesia services provided in the hospital setting into a fixed payment per discharge. The payment would be made not to the physicians who provide the services but to the hospital or the medical staff. In 1987, after extensive study and debate, the Congress rejected a virtually identical proposal. Since then, the Congress has adopted a resource-based fee schedule for pathology and other physician services. We urge you to reaffirm your opposition to the bundling proposal.

The Administration's proposal asserts that the bundling proposal would give physicians and hospitals the incentives to be cost-conscious, provide only medically necessary services, and eliminate the provision of marginal services. We can think of no manner in which the bundling proposal would accomplish this. Instead, hospitals and physicians would be unfairly burdened by federal requirements imposing new relationships among them, a burden which would be destructive to development of voluntary collaborative arrangements at the local level that could serve to contain the growth in health care costs while preserving the quality of and access to health care services.

The College believes that the interests of the government, of patients, and of physicians as patient advocates are best met when payment for physician services is made to the physician who provides the service without mandated intervention of another party, such as a hospital or medical staff. The College also believes that decisions about the relationships between hospitals and pathologists and pathologists and other physicians are best handled at the local level, so they can respond to local health care needs and local market conditions. Micro-management of local relationships between health care providers by the federal government will only harm physician-to-hospital, physician-to-physician, and physician-to-patient relationships and over time erode the quality of health care.

Pathologists, and all other specialties, are already very actively engaged in development of innovative collaborations and networks of health care service delivery that only a few years ago had not been contemplated. Those efforts vary in structure and size from region to region, of necessity having been structured to meet the needs of the local area. We urge the Subcommittee to allow those types of voluntary and very competitive efforts to continue and

not to dampen such efforts by imposing a new federal structure for payment of pathology services.

II. RVS Fee Schedule Update For 1994

The Administration's proposal would give a Medicare relative value scale fee schedule update for 1994 of approximately two percentage points less than the full update that would otherwise be allowed, with a full update only for primary care services.

The College is willing to work with the Subcommittee and Congress to discuss a reduced RVS fee schedule update for 1994 as physicians' contribution to attempts to reduce health care spending and to reduce the budget deficit. There is no sound basis for subjecting pathology to a more onerous reduction than is applied to physicians in general. Instead of imposing a bundling initiative for pathology services, we urge the Congress to include pathology in whatever update or reduction is generally applied to physicians for 1994 using the payment system that is currently in place.

III. RVS Practice Expense Component Reductions

The Administration's proposal also includes a reduction in 1994 through 1996 of the practice expense relative value component in the Medicare RVS. Our understanding is that the basis for this proposal is the Physician Payment Review Commission recommendation that the Health Care Financing Administration conduct studies to allow resource-based practice expense relative value units to be phased-in beginning in 1997.

The College is not opposed to resource-based practice expense components. In fact, the College has been proactive in the development of resource-based components by funding an external study of the practice expenses incurred by pathologists in the provision of services subject to the Medicare relative value scale. Those data now form the basis of the pathology technical component values.

We do oppose arbitrary changes in the Medicare practice expense relative values prior to completion of studies suggested by the PPRC. The Medicare RVS is only in its second year of implementation. Confusion, misunderstanding, mistakes, and other implementation problems are still in the process of being resolved. Yet another change in a fundamental part of the RVS fee schedule, the practice expense components, would be unfair to physicians and confusing to all involved. The College urges you to allow the relative value practice expense components to go unchanged until a time when more accurate data on what they should be are available.

IV. Reductions in Payment for Clinical Laboratory Services

The budget proposal includes a provision to reduce national caps on the Medicare clinical laboratory fee schedule from 88% to 76% of the national median of the carrier-specific fee schedules. Apparently there would be some potential for differential adjustments.

Since its beginning in 1984, the Medicare clinical laboratory fee schedule has been a favorite target for budget reduction efforts. Attached is a summary of the reductions and other changes in the fee schedule over the past nine years (Attachment A). This history alone should give pause to any proposals for additional reductions for these services. The current proposal is additionally troublesome because of its size — reduction from 88% to 76% is a dramatic reduction that the College must oppose, because it would drive many small laboratories out of the market and reduce local access to these services.

However, it has been sometime since the clinical laboratory fee schedule has been looked at other than as a budget saver. The College would appreciate the opportunity to work with you to resolve some glaring inequities in payment for certain services subject to the clinical laboratory fee schedule. We are also willing to discuss reductions in payment under the fee schedule.

In particular, the Medicare payment policy for Pap smear testing of women is totally contrary to federal attempts to ensure the quality of Pap smears and to encourage Medicare beneficiaries to avail themselves of this benefit. In 1988, the Congress passed the Clinical Laboratory Improvement Amendments which established stringent new requirements and restrictions on the provision of cytology services, especially Pap smears. Personnel requirements, workload restrictions, proficiency testing quality assurance mandates, and other CLIA '88 requirements have greatly increased the cost of Pap smear screening. The following year, in 1989, the Congress recognized the importance of the Pap smear as a preventive health care service and added to Medicare benefits a provision for reimbursement of a screening Pap smear every three years or more often for women at high risk of developing cervical cancer. The 1989 provision explicitly provided for coverage of both the screening by a technologist and a physicians' interpretation when medically necessary.

Nevertheless, Medicare payment for the technologists' screening service under the clinical laboratory fee schedule was capped nationwide in 1992 at \$7.89, well below the cost of this service. Information from cytology laboratories indicates that the cost of the screening Pap smear is somewhere between \$10 and \$20.

In addition, with implementation of the Medicare relative value scale, the Health Care Financing Administration arbitrarily and without opportunity for public comment eliminated separate payment for physician interpretation of outpatient Pap smears. Pathologists are required under CLIA to review and diagnose all abnormal Pap smears. Prior to 1992, the Medicare program made separate payment for these interpretations. The pathologists' Pap smear interpretation was studied by Harvard during the relative value studies and a relative value has been established for the service on that basis. Were the Medicare relative value scale fully implemented, and using the current \$31 conversion factor, the average payment nationwide for a pathologists interpretation of a Pap smear would be about \$25.

The Administration's policy regarding Pap smear interpretations is that payment for the interpretation is included in payment for the technologists' review under the clinical laboratory fee schedule, beginning January 1, 1992. However, the clinical laboratory fee schedule payment was not increased to include payment for these interpretations. Instead, beginning last year the \$7.89 cap, already well below the cost of Pap smear screening, was merely deemed to now include payment for a pathologists' interpretation.

Clearly this is a problem from several perspectives. First, the payment for the technologists' review is inadequate for the services that it has been intending to cover since 1984. If indeed there ever was any payment in the clinical lab fee schedule for pathologists' interpretations it was not on the basis of resources as those data were not available until the Harvard studies were completed. The Medicare relative value for the interpretation of a Pap smear is the federal statement of the resources involved in pathologists' interpretation of Pap smears, not the Medicare clinical laboratory fee schedule. In addition, pathologists in hospital practices generally do not receive the clinical laboratory fee schedule amount at all; that payment goes to the hospital. As discussed above in another context, we strongly believe that it is in the best interest of the government, physicians, and patients for Medicare payment for physician services to be made to those who provide the services not to another party.

The College is willing to work with the Congress and the Administration to discuss reductions in national caps for clinical laboratory fee schedule services, including differential adjustments, with the provision that problems with the payment policy for Pap smears be corrected.

V. Physician Ownership, Referral, and Direct Billing

The Administrations' proposal includes an extension of the current Medicare prohibition on ownership and referral arrangements for clinical laboratory services to additional services. H.R.345, the Comprehensive Physician Ownership and Referral Act of 1993, would address those issues and would extend the prohibition to all payers.

Consistent with American Medical Association policy, the College of American Pathologists supports limitations on self-referral. The College believes, however, that prohibitions on physician ownership and referral arrangements must, in order to be equitable and effective, create a level playing field. That is, there should not be exemptions for certain types of services that will produce distortions in the market and adversely affect the quality of those exempt services.

The current Medicare prohibition on self-referrals went into effect on January 1, 1992, and applies to all clinical laboratory services, including tissue pathology and Pap smears. We are concerned about proposed exemptions to the prohibitions on self referral in H.R. 21 and H.R. 345 for interpretation of tissue pathology, Pap smear slides, and the provision of other cytology services. Prohibitions on self referral should include tissue pathology and cytology services as well, to assure that there is a level playing field in arrangements for these services. The College urges that the current Medicare prohibition on self-referrals for clinical laboratory services, including tissue pathology and Pap smears, be retained and included in proposals to expand self-referral prohibitions to all payers.

In addition, the College firmly believes that a direct billing requirement goes hand-in-hand with prohibitions on self referral. Since 1984 there has been a direct billing requirement for services under the Medicare clinical laboratory fee schedule (clinical diagnostic laboratory testing). Payment can be made only to the entity that provides the services, with an exception for referrals between laboratories that are independent of a physicians' office. Physician pathology services subject to the Medicare relative value fee schedule are not subject to this requirement. For those services, an ordering/referring physician can purchase the service from pathologists and bill the Medicare program themselves, although they have not provided the service.

The College urges the Congress to expand the direct billing requirement for Medicare to pathology services subject to the Medicare relative value scale, and in any legislation that expands self referral prohibitions beyond Medicare to include a direct billing requirement for anatomic and clinical laboratory services.

VI. Graduate Medical Education Payments

The Administration's budget proposal would change Medicare payment policy for direct Graduate Medical Education such that payment would be based on a national average per resident amount and would give greater weight to primary care residencies.

The College of American Pathologists appreciates the need to ensure adequate access to primary care services through incentives for medical students to enter those areas of medical practice. We want to make you aware, however, of a growing problem in recruitment and retention of pathology residents, and of the implications of that problem for an adequate supply of pathologists in the near future. Any differential weighting of specialty residency programs should be based on a study of the need for residencies in each specialty, not an across-the-board reduction in non-primary care funding.

Pathology is not a large specialty, despite the fact that pathologists' services are required in almost every hospital setting and are considered an essential component of medical care in all communities. The American Medical Association listed fewer than 1000 pathologists in 1940, the first year that such data are available. As with other specialties, in the years following World War II pathology experienced a growth in the number of medical students entering the specialty. Even so, the proportion of physicians who are pathologists reached a peak of only 3.1% in 1970 and has declined since then. Likewise, the number of pathology training programs in Graduate Medical Education has steadily declined since the late 1960's from over 600 to 200.

We are now in the period during which pathologists who trained and entered practice following World War II are leaving practice. Pathologists currently practice 25 to 30 years. Average age at completion of residency training is 34 years; average age at retirement is 62; and there is an average of 6.86 deaths per 1000 pathologists per year. We anticipate that one

third of the pathologists who entered practice between 1940 and 1965 will have reached retirement age by 1994. The specialty is losing an average of 1.87 pathologists per day.

In contrast, problems in recruitment and retention of pathology residents are producing an average of only 0.96 newly trained pathologists per day. Attrition is a significant problem in pathology - approximately 30-40 percent of pathology residents fail to finish training. When the 25% of pathologists who pursue careers in academic pathology, the military service, forensic and government jurisdictions, and industry are eliminated, this leaves less than 400 new pathologists a year to fill the anticipated 600 openings in community pathology practice.

We do not know of the exact number of pathologists that is needed in the United States; we know of no data that will give one this number. We do believe that the decline in physicians entering pathology practice, combined with the graying of practicing pathologists, produces a situation that will likely produce a shortage of pathologists by the year 2000. Literature supporting our concern is attached (Attachment B).

As consideration of reforms in payment for Graduate Medical Education proceed, we strongly encourage the Congress not to adopt a restructuring of the federal payment for Graduate Medical Education that either gives incentives for pathology residencies to be reduced in number or quality, or creates additional disincentives for medical students to enter pathology practice. These disincentives are already in place and working, too well in our estimation.

Conclusion

The College of American Pathologists understands that physicians will be expected to contribute to the effort to reduce federal health care spending and the budget deficit. Pathologists want to be involved in how that contribution is configured and to ensure that pathology does not bear a disproportionate share of the load. Pathology and laboratory medicine has already undergone a series of reform initiatives over the last decade. We should not be singled out for additional reductions and changes beyond what all physicians in general will bear.

In summary, bundling of pathology services into a payment made to another entity is a totally unsound idea that has been rejected by the Congress previously and should be so again. Reductions in practice expense relative value components without adequate data in that regard are not an intermediate step to a resource-based system but are just a budget reduction mechanism. We urge you not to confuse the two with adoption of this intermediate proposal.

We are willing to work with the Congress to address pathologists' and laboratory medicine's contribution to health care spending reductions, both with regard to the RVS fee schedule and to the clinical laboratory fee schedule.

Thank you for the opportunity to testify today before the Subcommittee on Health.

Major Restrictions in Payment for Medicare Clinical Laboratory Services:

July 1984: Clinical Laboratory Fee Schedule Established

- ◆ Carrier fee schedules were implemented for clinical laboratory services performed in hospitals for outpatients, in physicians' offices, and in independent laboratories. Payments were set at 60% of prevailing charges for independent laboratories and physicians' offices; and at 62% for hospital outpatient services.
- ◆ Mandatory assignment was instituted for independent laboratories and hospitals.

July 1, 1986: Fee Schedule Caps Established

- ◆ Carrier fee schedule amounts were capped at 115% of the median of all fee schedule amounts.

January 1, 1987: Payments Reduced; Assignment Expanded

- ◆ Hospital fee schedule amounts were reduced from 62% to 60% of the prevailing charge, except for hospitals with 24 hour, 7 day a week emergency room services.
- ◆ Physicians' office laboratories were required to accept assignment.

January 1, 1988: Update in Fee Schedule Eliminated

- ◆ Laboratory fee schedule inflation updates were eliminated.

April 1, 1988: Payments Reduced

- ◆ The 2% differential was eliminated for all hospital laboratories except those operating qualified emergency rooms in sole community hospitals.
- ◆ Fee schedules for high volume tests were reduced by 8.3%.
- ◆ The fee schedule caps were reduced from 115% to 100% of the median of all fee schedules.

January 1, 1990: Payments Reduced

- ◆ The fee schedule caps were reduced from 100% to 93% of the median of all fee schedules.

January 1, 1991: Update Limited; Payments Reduced

- ◆ The fee schedule caps were reduced from 93% to 88% of the median of all fee schedules.
- ◆ Laboratory fee schedule inflation updates were limited to 2% (4.3% was scheduled).

January 1992 and 1993: Updates Limited

- ◆ Laboratory fee schedule inflation updates are limited to 2% regardless of inflation.

Special Article

National Pathology Manpower Survey of 1988

Manpower Needs in Community Hospitals and Private Laboratory Practice

Ellis S. Benson, MD; Roger D. Smith, MD; Robert E. Anderson, MD; Daniel Tholen, MS

• The survey of manpower in community hospital and private laboratory practice of pathology of 1988 presented herein verifies the conclusions of the 1986 survey that a growing deficit of manpower in this sphere of practice is highly likely in the next few years. It appears that the deficit will be even larger than that predicted by the 1986 survey. Steps are urgently needed to increase the flow of graduating medical students, especially those of top quality, into our specialty.

(*Arch Pathol Lab Med.* 1990;114:566-569)

This is the sixth of a series of articles concerning pathology manpower needs in the United States and the second such study using the National Pathology Manpower Database (NPMDB).^{1,2} The latter consists of a subset of practicing pathologists defined so as to be representative of the discipline in terms of type of practice, age, gender, and geographic location. The first survey using the NPMDB was performed in 1987 and showed an impending serious shortage of pathologists engaged in practice in community hospitals and/or private laboratories, a group henceforth referred to as *community pathologists*. This article which is concerned with community pathologists, also deals with data from the second yearly survey of a longitudinal study of this practice group initiated to determine the kinetics of manpower and especially losses to the specialty due to death, retirement, and major career changes. Further, the NPMDB is being exploited to determine the characteristics of community practice and detect changes that have implications for future manpower needs in pathology.

MATERIALS AND METHODS

The development and structure of the NPMDB is described in detail elsewhere.¹ In brief, a representative subset of 4669 pathologists was defined. Of this sample, 2469 indicated a willingness to participate in

repeated surveys. In comparison with the American Medical Association (AMA) database, the latter group was shown to be representative of the universe of practicing pathologists in terms of age, practice setting, and geographic location. Only in terms of gender was there a difference between the NPMDB and the AMA database with a deficit of women in the former (12.4%) in comparison with the latter (19.6%).

THE NPMDB BY DEFINITION AGES

To keep this subset representative of the universe of pathologists, new persons are added to replace previous participants who retired, died, changed to a new career other than pathology, or declined to continue to participate in these surveys. As a result, our survey includes 580 community pathologists who participated in the 1987 study and 206 persons who did not, who were added on the basis of demographic representation.

The survey form consisted of a two-page questionnaire in two parts, both of which required the respondents to check choices and fill in specific numerical information. The first part was to be completed by the individual pathologist who received the form. The requested information concerned the pathologist's current professional activities and career plans. The second part asked for information concerning the group in which the pathologist practiced to include group size, professional responsibilities, and manpower changes that had occurred over the prior 3 years and those anticipated for the subsequent 1 year and 2 to 5 years. The 1988 survey form was similar to the one employed in 1987 except that an opinion poll was omitted because it provided little useful information.

The questionnaire was sent with a cover letter to 786 pathologists in January 1988. Subsequently, 70 of the 786 pathologists were excluded on the basis of a determination that they had entered federal service or academic pathology or declined to participate, resulting in 716 as the surveyed group. After a second mailing in February 1988 and one in March 1988, 562 completed responses were received by April 15, 1988, for a response rate of 78.5%. The data were analyzed using a computer (IBM model 7341) at the College of American Pathologists Computer Center in Traverse City, Mich. An additional 20 respondents who returned their questionnaires after individual data analysis were included for analysis of practice group data, resulting in a response rate of 81% for surveyed practice groups.

RESULTS

Table 1 compares this study sample with the AMA database in terms of general demographics. Overall, the two groups are highly comparable except for a deficit of women and a modest

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From the Department of Laboratory Medicine and Pathology, University of Minnesota School of Medicine, Minneapolis (Dr. Benson and Smith); Department of Pathology, University of New Mexico School of Medicine, Albuquerque (Dr. Anderson); and the College of American Pathologists Computer Center, Traverse City, Mich (Mr. Tholen).

Reprint requests to the Department of Pathology and Laboratory Medicine, University of Cincinnati School of Medicine, Cincinnati, OH 45267-0529 (Dr. Smith).

Table 3.—Anticipated Changes of 562 Responding Pathologists

Change	1 Year	Subsequent 4 Years	Total at 5 Years
Retire	17.0	79.0	96.0
Change specialties	12.0	10.0	22.0
Other*	3.5	11.5	15.0
Death†	3.85	17.42	21.27
Total	36.35	117.92	154.27
Extrapolated to 11 423 community pathologists	739	2397	3136

* Full-time to part-time, law, forensic pathology, hospital administration, and industry.

† Age/gender adjusted actuarial data from statistical abstracts, United States Census Bureau, 1987, page 71.

Table 4.—Anticipated Changes of 459 Pathology Groups*

Change	1 Year	Subsequent 4 Years	Total at 5 Years
Retire	46	235	281
Resignation/termination	36	50	86
Full-time to part-time minus part-time to full-time	22	21	43
Vacant positions	41		41
Subtotal	145	306	451
Extrapolated to 11 423 community pathologists†	634	1336	1972
Projected new positions	115	185	280
Extrapolated to 11 423 community pathologists	503	722	1225
Total‡	1137	2060	3197

* Encompasses 2612 community pathologists in groups of two or more.

† Does not include deaths.

Table 5.—Loss of Pathologists From 459 Practice Groups During the Past 3 Years*

Reason	No. Unavailable	Extrapolated to Universe†
Resignation	47	643
Retirement	59	433
Termination	27	182
Deaths	25	109
Total	308	1347

* Results based on 3 years before survey and encompass 2612 community pathologists.

† Universe constitutes 11 423 community pathologists.

pated positions during the next 5 years. Using these data, without the addition of unanticipated attrition because of death, it was determined that, including the current vacancies, there would be 634 positions open within 1 year and an additional 1338 positions vacated over the next 2 to 5 years (Table 4). If new positions for the 459 practice groups of two or more pathologists are included, based on this group data there is an anticipated national need for 3197 new pathologists over the next 5 years, in addition to undetermined losses due to death.

To get some idea of the kinetics of change in pathology practice groups, we asked how many individuals had left the surveyed groups over the past 3 years due to resignation,

retirement, termination, or death. Data from the 459 groups extrapolated to the entire population of pathologists indicate a turnover of approximately 1346 individuals or approximately 450 per year (Table 5). This figure does not include openings because of vacant positions or new positions and compares well with the 454 anticipated open positions in groups based on retirement (46), resignation (36), or other changes (22) without currently vacant positions and extrapolated for 11 423 pathologists as listed in Table 4 ($104 \times 4.3732 = 454$).

COMMENT

The primary aim of the longitudinal survey of pathologists in community practice is to determine the number of individuals lost to this practice setting over time to project the need for new pathologists. The NPMD was constructed to make such a survey possible without tracking all 11 423 individuals in community practice. The surveyed group is, with the exception of gender, demographically representative of the 11 423 pathologists when compared with the AMA database, the most comprehensive listing of US pathologists based on practice characteristics and geographic distribution. Ideally, the longitudinal survey should document the actual percentage of retirements, deaths, and other changes in the previously surveyed group, so that the predictions made following the 1987 survey could be validated. Although we were unable to trace all the nonresponders who were in the first survey group, follow-up of most of them indicates that the 1987 projections are surprisingly accurate. Surprising because, although individual pathologists apparently change even in their 1-year career plans rather acutely, these last-minute changes tend to balance out in terms of manpower projections. For example, of the 9 pathologists who indicated in 1987 that they planned to retire in 1 year, only 3 actually did so. However, they were joined by 4 others who retired sooner than anticipated. Of the 6 remaining individuals who had indicated retirement within 1 year, 3 were working part-time, 2 were working full-time, and 1 was unavailable for follow-up. Of the 16 pathologists who indicated in the 1987 survey that they planned career or specialty changes within the next year taking them out of community practice, only 3 had actually followed this course. Eight continued in full-time practice; 5 went from full-time to part-time; 1 went from part-time to full-time; and 2 were unavailable for follow-up. However, 2 others who had anticipated major changes at 5 years had already made this change by 1988. A significant percentage of the 70 individual respondents to the first survey who failed to respond in the second one could not be readily traced and are presumed to be retired from pathology or dead. This suggests that the projections made in 1987 anticipating approximately 30 of 629 respondents leaving practice over 1 year was probably on the low side.

With the exception of carefully following a large cohort of practicing pathologists and exhaustively tracking down nonresponders to confirm that they have left the practice or died, the next best determination of attrition is based on the responses of individual pathologists indicating anticipated change over the next year and/or 2 to 5 years added to the actuarial death rate based on the age and gender of the

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Editorial

Key Discriminators in the Manpower Equation

The severity of the current manpower situation in pathology has been carefully documented both with respect to community practice and to academia.¹⁻⁴ The sudden emergence of the present deficit, a shortfall that is expected to worsen significantly over at least the next 12 to 15 years, caught most pathologists by surprise. Their initial response was one of disbelief. Once convinced of the severity of the situation and of the implications for the future of the discipline, however, these same individuals next ask, "Well, how badly are we doing?" This seemingly straightforward question is, in fact, much more difficult to address than might be anticipated.

In the current issue of the *Journal*, Vance et al⁵ provide a wealth of information concerning trainees in pathology. These individuals, and their successors, constitute a major piece of the manpower puzzle; with rare exceptions, pathology training programs in the United States provide all academic, community hospital, and government-employed pathologists for this country. As a consequence, the prognosis for pathology manpower is largely dependent on the kinetics of the training situation. But which of these numbers are most important and do they provide any reason for optimism? More importantly, can any single parameter serve as a benchmark for success?

Historically, persons interested in pathology manpower have been obsessed with "the match." Every spring the National Resident Matching Program (NRMP) publishes, on a program-by-program basis, the number of senior medical students who selected an institution as well as the number of positions offered. In the past, and especially during the period from 1970 to 1988, match results were a good indicator of the manpower situation. However, a number of problems have emerged to weaken the match's value as an indicator. With the implementation of the fifth year, 10% to 20% of medical students planning a career in pathology have elected to match in another discipline (internal medicine, pediatrics, etc) for their first postgraduate year. In addition, pathology has become the alternative career choice of an increasingly large number of persons who started out in another specialty and then, for a variety

of reasons, modified their plans. Program directors seem to accommodate these transplants by shifting slots out of the match. Finally, pathology also suffers significant attrition during the training process. This phenomenon, which may involve 30% to 40% of all entrants to the training process, is not reflected in match results. Thus, the total number of positions offered and filled via the NRMP only indirectly reflects the trainee manpower situation and is a generally poor indicator of the supply side of the manpower equation.

The total number of training programs and resident positions and the proportion of positions filled have similar drawbacks as prognostic barometers. Each fails to reflect the attrition problem. Some account must also be taken of training programs that chronically underfill, even though recent efforts by the Pathology Residency Review Committee have markedly reduced the number of such institutions. The number of trainees in each year of training is an important piece of data, but only in association with the size of the entering class, so as to permit the calculation of attrition.

Historically, pathology training program directors have tended to fill open slots with graduates of non-US medical schools rather than leave such positions vacant and susceptible to reassignment to another specialty. As a result, roughly 25% of the practitioners of pathology today are graduates of foreign medical schools (FMGs). The proportion of FMG trainees is therefore an indicator of our success, or lack of same, in attracting US graduates. However, at best, this indicator represents an indirect measure of success. It also undoubtedly offends many excellent pathologists who either (1) trained abroad or (2) competed successfully with American graduates for a US training slot.

Clearly, the most straightforward approach to the issue is to examine the relationship between (1) the number of practicing pathologists lost to the discipline (due to death, retirement, etc) versus (2) the number of graduating house staff entering practice. With steady-state kinetics, this number would be 1.0. Results from the most recent manpower surveys indicate that in community practice, for example, this figure is 0.41.^{4,5} Un-

Current Topics

The Accelerated Graying of American Pathology

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The results of the 1988 survey of the National Pathology Manpower Database (NPMD) have been analyzed and join an increasing body of evidence in support of a current deficit of pathologists engaged in community practice in the United States, a shortfall that promises to worsen for the foreseeable future.¹⁻³ A more recent assessment of military pathologists and others employed by the federal government also reveals a growing shortage, one unlikely to be negated by current and projected residents in the federal pipeline. We are currently in the process of reanalyzing the third component of the manpower equation, academic pathology; there is no reason, however, to think that the situation has improved since the last such survey in 1984 which demonstrated a marked shortage.⁴ In fact, discussions with pathology chairmen and preliminary analysis of the academic manpower data suggest that the situation has worsened significantly in the interim.

We recognize that it is difficult to understand the basis for the situation described above. It seems like just a short time ago that graduates of pathology training programs in the United States were experiencing difficulty in locating positions, especially in the community practice setting. A series of federal initiatives, concerned primarily with reimbursement, further confounded the manpower equation and prompted some to discourage medical students interested in a career in pathology. What then has changed? And what is the etiology of the current and impending shortage of pathologists?

In this presentation we will review the manpower kinetics in American pathology and show that the current shortage of both academic and community hospital-based pathologists was predictable on the basis of the demographics of pathologists and the

resultant disequilibrium between the number of persons entering and leaving the discipline. Furthermore, although this shortage is of moderate magnitude at present, it can be expected to worsen dramatically during the next 7 to 10 years. And finally, absent a marked increase in American medical students electing a career in pathology, this shortage can be expected to continue for the foreseeable future.

NUMBERS OF PATHOLOGISTS

Prior to World War II, there were relatively few pathologists in the United States. As shown in Fig 1, the American Medical Association listed fewer than 1,000 pathologists in 1940,⁵ the first year that such data are available. During the subsequent 45 years, however, the discipline grew by almost 16-fold to encompass 15,456 individuals. By contrast, during the same time period, the total physician pool grew by roughly threefold from 175,163 to 552,716 (Fig 2).⁶ The result has been an increased proportion of physicians who are pathologists, a figure which reached a peak of 3.1% in 1970 (Fig 3).

DEATHS AND RETIREMENTS

Prior to World War II, a rough equilibrium appears to have existed with respect to manpower kinetics in pathology: the number of persons entering the discipline approximated those leaving due to death, retirement, etc. After the War, and especially from 1955 to 1970, the field of pathology expanded dramatically and entrants markedly exceeded those leaving. Today, however, these post-War entrants are being lost to the discipline by retirement and death.

It stands to reason that the exponential character of the growth curve of pathologists experienced from 1955 to 1970 must subsequently be mirrored by a similar death/retirement curve. The interval between these two curves will be the average professional lifespan of the involved individuals. In pathology, this figure is currently 25 to 30 years as based on the following observations: average age at completion of residency training, 34 years⁷; average age of retirement, 62 to 65 years (see below); and a current average of 6.86 deaths/1,000 pathologists per year.⁸

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Key words: graying of pathology.

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TABLE 1. Anticipated Vacancies Among Community Pathologists: 1986 National Pathology Manpower Survey*

Change	1 Year	Subsequent 4 Years	Total at 5 Years
Retire	9.00	82.00	91.00
Change specialties	5.00	7.00	12.00
Other major career changes†	11.00	19.00	30.00
Deaths‡	2.55	21.98	24.53
Total	27.55	129.98	157.53
Extrapolated to 11,476 community pathologists	502.60	2,371.26	2,873.86

* Results based upon responses from 629 community pathologists.¹

† Hospital administration, change to nonmedical career.

‡ Based on 1984 actuarial tables for teachers adjusted for age and gender.

resident-graduates per year for the foreseeable future.

KINETICS OF PATHOLOGY MANPOWER

Tables 1 and 2 show anticipated vacancies in the community practice of pathology. Historically, 70% of the graduates of residency training programs (roughly 250 persons per year) have gone into community practice with the remainder electing careers in academic pathology and government service. Keeping these figures in mind, the magnitude of the shortfall of pathologists in the community setting is evident in Table 3. The numbers of current and anticipated vacancies greatly exceed the supply of pathology house staff completing their training and entering the job market. Comparable data derived from the 1984 survey of academic pathologists and departmental chairmen⁴ are also included in Table 3. In sum, the discipline is losing an average 1.87 pathologists per day; as of July 1990, these positions are being replenished on average by 0.96 newly minted graduates of our training programs per day. In other words, the manpower equation is in marked disequilibrium; gains only represent slightly over half of losses. And as we enter the steep portion of the re-

TABLE 2. Anticipated Vacancies Among Community Pathologists: 1988 National Pathology Manpower Survey*

Change	1 Year	Subsequent 4 Years	Total at 5 Years
Retire	17.0	79.0	96.0
Change specialties	12.0	10.0	22.0
Other†	3.5	11.5	15.0
Deaths‡	3.854	17.421	21.275
Total	36.354	117.921	154.275
Extrapolated to 11,423 community pathologists	738.91	2,396.82	3,135.73

* Results based on responses from 562 community pathologists.²

† Full to part-time, law practice, forensic pathology, hospital administration, industry.

‡ Age/gender-adjusted actuarial data.³

TABLE 3. Results of Recent Manpower Surveys and Implications for the Future

Segment Surveyed	Year of Survey	No. of Vacancies at Time of Survey	Anticipated Losses*	
			1 Year	5 Years
Academic	1984	272	137†	649†
Academic	1990	367	145	Unknown
Community hospital	1986	170	503	2,874
Community hospital	1988	179	739	3,136
Government service‡	1989	14	25	Unknown

* Due to retirement, death, change in specialty, relocate to industry, etc.; losses due to death in academic sector are based on the assumption that academic and community hospital pathologists exhibit comparable age and gender distributions.

† Does not include anticipated losses in community practice.

‡ Includes only uniformed services; data for Veterans Administration not available.

irement curve, the situation can be expected to worsen.

THE FUTURE

As indicated above, barring unforeseen events, the current disequilibrium in pathology manpower will become increasingly severe until at least 2007 or the year when the average person entering the discipline at the end of the exponential growth phase (1975) can be expected to retire. There are a number of variables that confound manpower data in pathology. Unfortunately, each of these would tend to suggest that the situation in the future may be even worse than currently anticipated. These variables relate to age of retirement and numbers of foreign graduates entering the discipline.

Currently there is a tendency for physicians in general to retire at a younger age than in the past¹⁰ (and unpublished data). Pathologists not only share this tendency but may actually be trendsetters. In 1986, the average estimated retirement age of community pathologists in the NPMD was 62¹ and in 1988 it was 65.² In 1988, 24.5% of community pathologists in the NPMD were 55 years of age or older and the mean age was 52 years.² In other words, almost half of the discipline can be expected to retire in the next 10 to 15 years (assuming that they don't die first). This tendency toward early retirement is reflected in the relative deficit of pathologists over 65 years of age in comparison with other physicians as shown in Table 4. This table also reveals a highly uneven representation of pathologists by the indicated age groups, a phenomenon which relates in large measure to recent recruitment problems¹¹ that have resulted in a paucity of pathologists in the younger age groups.

In the past, shortfalls of American pathologists have been partially muted by foreign medical school graduates (FMGs) of both American and foreign heritage. As a consequence, approximately 40% of community pathologists in the NPMD are graduates of other than US medical schools. All indications at

even stabilize (albeit at a distinct shortage level) under the most optimistic circumstances until the next century.

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Chairman STARK. Thank you very much.

I want to apologize to the panel. We are faced with a series of three votes, which will consume the better part of half of an hour, and it would not be my intention to ask you to wait.

I think you heard the questions that the Chair addressed, at least, to the previous panel regarding cost controls versus price freezes, and I would add my admonition that there will be—you all may be required to work for staff-modeled HMOs, if managed competition evolves, and that will be out of my hands. You will all be working for a salary. And that is the logical outcome of the Jackson Hole approach.

It will be an interesting couple of months ahead as we see what happens. This will not be the last meeting we will have this year. Once we do this, I understand we will be doing reform, and I think we will be going back through the same list of questions.

So if you will, I would appreciate any additional comments you might care to address to the Chair privately or to be included in the record, and I look forward to working with each of you and your representatives here.

I assure you that we will not go off blindly making changes, but I also assure you that we are quite serious in stopping the rate of increase in the aggregate, or lowering that rate of increase, not necessarily cutting anybody's fees, although that may be the result of various changes, but certainly seeing that we, in the next 5 years, get the rate of increase in the aggregate cost of medical fees and services down to about 6 percent a year growth.

That is not going to be fun. That means that we are taking billions of dollars out of your profession that you could anticipate now. And I am just saying that you guys are not going to like it, and the hospitals are not going to like it, and the pharmaceutical companies are not going to like it, and I do not suppose members of Congress are going to like having their pensions cut.

But this is what we are faced with. I hope we can do it together, so that basically all patients, many of whom do not get to see you except through the emergency room, and the well-to-do—will get the benefit of your excellent treatment.

I look forward to working with you. Thank you very much for participating today. I appreciate it. And the committee is in recess.

[Whereupon, at 12:40 p.m., the hearing adjourned.]

[Submissions for the record follow:]

TESTIMONY OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

The American Association of Nurse Anesthetists (AANA) is the professional association that represents over 25,000 certified registered nurse anesthetists (CRNAs), which is more than 96 percent of the nurse anesthetists in the United States. For those new members of the committee who may be unfamiliar with CRNA practice, we will provide some background information for you in an attachment to this testimony.

The AANA appreciates the opportunity to provide testimony regarding the Administration's Fiscal Year 1994 budget proposal to bundle payments for inpatient radiology, anesthesiology, and pathology services into a hospital DRG payment (a RAP DRG).

AANA SUPPORTS ANESTHESIA REFORM BUT OPPOSES A RAP DRG

The AANA supports the need for health care reform in this country, due to skyrocketing health care costs and lack of access to health care by millions of Americans. We believe that anesthesia providers must do our part in terms of helping to reform inefficiencies in the anesthesia system that result in unnecessarily high federal expenditures. But the AANA opposes the Administration's RAP DRG proposal because its methodology does not appropriately address the role that CRNAs play in providing patients access to safe, cost-effective anesthesia services. The proposal ignores the fact that since 1989, CRNAs have the authority to be paid directly under Medicare Part B. The proposal only mentions medical staff and individual physicians.

CRNA PRACTICE ARRANGEMENTS

The 1992 AANA Membership Survey data indicates that approximately 42% of CRNAs are employed by a hospital, 33% are employed by a CRNA/anesthesiologist group, and 15% are self-employed, work for CRNA groups, or work as locum tenens (providing vacation/temporary relief). The remainder work in offices, clinics, surgicenters, universities, the military, the Veterans Administration, or the U.S. Public Health Service. AANA has historically believed that the marketplace should decide what CRNA/anesthesiologist practice arrangements should be.

The Administration's RAP DRG payment would be made to the medical staff, or to the hospital if the medical staff did not want to receive the payment. AANA's reason for opposing the proposal can be graphically depicted by the following possible scenario: a hospital contracts out for radiology and pathology services from a radiology/pathology group, but

employs CRNAs to provide anesthesia services. Under the Administration's proposal, the radiology/pathology group could receive the Medicare RAP DRG payment and then the hospital would be required to negotiate with that group for its portion of the payment for CRNA services. The AANA does not believe that hospitals should be placed in the position of having to negotiate with a radiology/pathology group to receive its appropriate share of payment for the services of its CRNA employees.

SUMMARY

The AANA believes that there must be reform in anesthesia payment under Medicare. However, the AANA opposes the Administration's RAP DRG proposal because its methodology does not appropriately address the role that CRNAs play in providing patients access to safe, cost-effective anesthesia services.

The AANA appreciates the support that this committee has historically shown for the value of CRNA services. Thank you for your consideration of our views on this issue. We request the opportunity to orally testify on any additional proposals for anesthesia payment reform that may come before the committee during this congressional session.

BACKGROUND ON CRNA PRACTICE

This attachment provides background information for you on the following CRNA issues:

1. History of nurse anesthesia,
2. Educational preparation,
3. Patient access,
4. Quality of care,
5. Cost-effectiveness of care,
6. Physician liability,
7. Clinical privileges,
8. History of Medicare anesthesia payment, and
9. CRNA Medicare rates.

History of Nurse Anesthesia

Nurses have been providing anesthesia services to patients within the U.S. since the late 1870's. Because there had been significant morbidity and mortality associated with the use of the "occasional anesthetist" for the administration of anesthesia, surgeons in the U.S. encouraged nurses to specialize in this field. At first, most nurse anesthetists learned their anesthesia in on-the-job training programs (similar to medical residencies of that day). The educational preparation and practice of CRNAs is quite different today.

Educational Preparation

There are currently 92 accredited nurse anesthesia education programs. The requirements for admission to a nurse anesthesia education program are:

- A Bachelor of Science in Nursing or another appropriate baccalaureate degree,
- A license as a registered nurse, and
- A minimum of one year of acute care nursing experience.

Nurse anesthesia education programs comprise 24-36 months of graduate course work including both classroom and clinical experience. The classroom curriculum emphasizes anatomy, physiology, pathophysiology, biochemistry, chemistry, physics and pharmacology as they relate to anesthesia. The major clinical component provides experience with a variety of anesthesia techniques and procedures for all types of surgery and obstetrics. Of the 92 nurse anesthesia education programs, 80% offer a master's degree. The other 20% of programs are modifying their curriculum to meet the requirement that all programs offer a master's degree beginning in 1998.

Patient Access Increased

CRNAs increase access to anesthesia services, by administering 65% of the 26 million anesthetics given in the United States annually. CRNAs are the sole anesthesia providers in 85% of rural hospitals. CRNAs provide anesthesia services for all types of surgeries, in all types of facilities, and for all levels of patient acuity.

Quality of Care Provided by CRNAs

CRNAs have the legal authority to practice anesthesia in all 50 states, without anesthesiologist supervision. There is no study which shows that the anesthesia care provided by an anesthesiologist is superior to that provided by a CRNA. In fact, the only studies that exist suggest that the quality of care is not significantly different.

The practice of anesthesia has gotten safer in recent years due to improvements in medications and technology advances that allow for increased patient monitoring. In fact, in 1990 the Centers for Disease Control (CDC) decided not to conduct a national multi-million dollar morbidity and mortality study on anesthesia. Doug Klauke, MD, Assistant Director for Science, Division of Surveillance and Epidemiologic Studies, Epidemiology Program Office, CDC, publicly stated that "the expected benefit of this multi-million study is clearly not justified."

Cost-effectiveness of CRNA Practice

A 1990 Department of Health and Human Services report presented the results of a study of nurse anesthesia manpower needs by the Health Economics Research, Inc. It estimated that the cost of delivering anesthesia services in a model that underutilizes CRNAs and overutilizes anesthesiologists will be \$1.2 billion more in 2010 than it would be under a more efficient model.

CRNAs have accepted mandatory assignment under Medicare. Anesthesiologists can balance bill Medicare beneficiaries. In 1992, only 49.3% of anesthesiologists were participating physicians.

Physician Liability

A physician or authorized provider is not automatically liable when working with a CRNA, nor is the physician immune from liability when working with an anesthesiologist. In Schneider v. Einstein Medical Center, 390 A.2d 1271 (Penn. 1978) and Kitto v. Gilbert, 570 P.2d 544 (Colo. 1977), the court found the physicians liable for the negligence of anesthesiologists because the physicians were in control of the anesthesiologist's actions. The question, as in the case of a physician working with CRNAs,

is whether the physician was in control of the acts of the anesthesiologists. Usually, this is a factual inquiry, and not a conclusion of law. There are many cases in which the courts have found that the surgeon was not in control of the CRNA and, therefore, not liable for the negligence of the CRNA. Cavero v. Franklin Benevolence Society (223 P. 2d 471, California, 1950), Fortson v. McNamara (508 So. 2d 35, Florida, 1987), Hughes v. St. Paul Fire and Marine Insurance Company (401 So. 2d 448, Louisiana, 1981), Kemalyan v. Henderson (227 P. 2d 372, Washington, 1954), Parks v. Perry (68 N.C. App. 22, North Carolina, 1984), Sesselman v. Mulenberg Hospital (306 A.2d 474, New Jersey, 1954). Numerous cases hold that mere supervision or direction of a CRNA is insufficient evidence to hold a physician liable for the CRNA's negligence. See, for example, Baird v. Sickler, 69 Ohio St.2d 652 (1982); McCullough v. Bethany Medical Center, 235 Kan. 732 (1984); Elizondo v. Tavaréz, 596 S.W. 2d 667 (Texas, 1980); Parker v. Vanderbilt, 767 S.W. 2d 412 (Tenn., 1988); Whitfield v. Whittaker Memorial Hospital, 210 Va. 176 (1969). It is clear from the case law that in order for a physician to be liable for the acts of the anesthesia administrator, the physician must be in control of the administrator's actions and not merely be supervising or directing the administrator.

There is no greater liability when surgeons or obstetricians work with CRNAs. The principles governing liability of a surgeon when working with a CRNA are the same as those governing the liability of a surgeon when working with an anesthesiologist. The courts do not look at the status of the anesthesia administrator but, in most states, at the degree of control the physician exercises over the administrator - whether that administrator is a CRNA or an anesthesiologist. The issue in each case is the extent to which the physician has control over the anesthesia administrator. Thus, a court may render different conclusions for cases that involve a physician working with a CRNA - or, for that matter, a physician working with an anesthesiologist - if the physician controlled the CRNA in one case but not in another. Every state permits CRNAs to work without anesthesiologist supervision. Some state licensing laws require that CRNAs work under the "supervision" or "direction" of a physician. Such "supervision" or "direction" does not require that the CRNA be supervised by an anesthesiologist. The Joint Commission on Accreditation of Healthcare Organizations does not require that CRNAs be supervised by an anesthesiologist.

The nature of anesthesia requires the constant vigilance of the anesthesia provider. Studies of anesthesia related incidents show that most are avoidable. Most mishaps result from a failure of the practitioner to vigilantly monitor the patient, not from lack of education. Vigilance has been the hallmark of nurse anesthesia education since the profession's creation. The AANA has been publishing standards calling for increased monitoring since 1974. In 1986, after publication of studies of anesthesia related

incidents showed that most could have been avoided, the HARVARD MINIMAL MONITORING STANDARDS ON ANESTHESIA CARE were published in the Journal of the American Medical Association (the AANA was the first organization to endorse the then controversial Harvard Standards). Since then, the AANA has issued even more explicit monitoring standards.

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists first receive medical education while CRNAs first receive nursing education. However, the anesthesia part of the education is very similar for both providers. CRNAs and anesthesiologists are both educated to use the same anesthesia process in the provision of anesthesia and related services.

Regarding malpractice insurance, St. Paul Fire and Marine Insurance Company has been the underwriter for the AANA's Professional Liability Insurance Program for more than eight years. St. Paul, the largest medical malpractice underwriter in the United States, bases their yearly professional insurance premium for CRNAs on previous claim losses. For the last three years, there has been an average annual decrease of 6% in CRNA professional liability insurance premiums due to the decreased number of claim losses.

Clinical Privileges

If there is insufficient reimbursement for medically directed CRNA services, then hospitals or anesthesiologist groups may no longer want to employ CRNAs. As a result, CRNAs may be forced to become independent practitioners and compete with anesthesiologists. However, there is not always an equal opportunity to compete. CRNAs are required in most hospitals to practice under a clinical privileging process. But it is sometimes difficult for CRNAs to secure hospital/facility clinical privileges due to exclusive contracts and restrictive medical staff bylaws which either prohibit or deter applications based on the class of provider, or require recommendation and/or approval by the Physician Chief of the Anesthesiology Department. These factors are often difficult to surmount because CRNAs with hospital/facility clinical privileges may be viewed as competitors of the anesthesiologists on staff at the hospital/facility. Consequently, the AANA urges Congress to mandate an open and equitable privileging process in all health care facilities receiving federal funding, which would allow access to all classes of providers.

History of Medicare Anesthesia Reimbursement

The issue of how to pay for anesthesia services when provided by CRNAs and anesthesiologists working together is not new. It is something that Congress, the Health Care Financing Administration (HCFA), and professional anesthesia associations have struggled with since the inception of Medicare in 1965. The following is a brief historical perspective on anesthesia reimbursement under Medicare.

1. As enacted in 1965, Medicare (Title XVIII of the Social Security Act) reimbursed hospitals under Part A for "reasonable costs" of anesthesia services provided by hospital-employed CRNAs. Anesthesiologists who employed and supervised CRNAs could bill under Part B as if they personally performed the case. Anesthesiologists who supervised CRNAs who were employed by a hospital could bill the same base units as if they did the case themselves, but their time units were halved.
2. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established conditions that anesthesiologists must fulfill in order to be paid for medically directing CRNAs. In addition, TEFRA limited to four the number of concurrent cases of medically directing CRNAs that an anesthesiologist could be reimbursed for.
3. The Social Security Amendments of 1983 created the Prospective Payment System (PPS). Under PPS, all hospital Part A payments were bundled into diagnosis-related groupings (DRGs). Hospitals would have been forced to pay for their CRNA employee costs out of the fixed DRG payments which they would receive. However, the CRNA costs included within the global DRGs had been very undervalued. Therefore, hospitals could not have recouped their actual CRNA costs through Medicare payments. This created a disincentive for hospitals to employ CRNAs. In addition, PPS precluded the unbundling of services. Therefore, anesthesiologists who employed CRNAs that worked in a hospital would have been forced to contract with that hospital to get the CRNA portion of the DRG.
4. The Deficit Reduction Act of 1984 established a pass-through provision for hospital-employed CRNA costs for a three-year period, assuring hospitals that they would not lose money by employing CRNAs. It also allowed an exception to the unbundling provisions in PPS, to accommodate anesthesiologists billing for their CRNA employees. However, due to the temporary nature of the pass-through provision, AANA immediately sought a legislative remedy that would provide for direct CRNA Medicare reimbursement.

5. The Omnibus Budget Reconciliation Act of 1986 (OBRA86) established direct reimbursement for CRNAs under Medicare Part B, effective on January 1, 1989. It also continued the existing forms of hospital and anesthesiologist billing for CRNA services under Medicare until December 31, 1988.
6. The Omnibus Budget Reconciliation Act of 1987 imposed reductions in base units for anesthesiologists who medically directed CRNAs. Anesthesiologists' base units were reduced by 10% when medically directing CRNAs in two concurrent procedures, 25% for three procedures, and 40% for four procedures.
7. The Omnibus Budget Reconciliation Act of 1989 created the resource-based relative value scale (RBRVS) system. During the implementation of RBRVS, the services of anesthesiologists were found to be 29% overvalued, not 18%, as had been originally estimated.
8. The Omnibus Budget Reconciliation Act of 1990 (OBRA90) statutorily established higher Medicare conversion factors for CRNAs. It is noteworthy that Congress did not view CRNA fees as overvalued, on the contrary, it increased CRNA conversion factors just a year after decreasing anesthesiologist conversion factors. OBRA90 also extended the 10%, 25%, and 40% reduction in base units for the concurrent medical direction of two, three, and four CRNAs respectively, until December 31, 1995. In addition, it reduced the weighted national average conversion factor for anesthesiology services by 7% in 1991, adjusted by geographic indices.
9. Under the RBRVS phase-in, 1992 payments per service for anesthesiologists were reduced on average by 11%.

Increased CRNA Medicare Rates Needed to Provide Equity

CRNA Medicare conversion factors have risen in recent years to correct a huge inequity in the CRNA conversion factors that HCFA established under the CRNA direct reimbursement law. OBRA86 directed HCFA to develop a CRNA fee schedule under which total payments for CRNA services would equal the estimated total amounts that would have been paid in 1989, if the services were included as inpatient hospital services. In January 1989, HCFA published an interim CRNA fee schedule that was 35% below what would have been paid under a continued Medicare Part A pass-through.

HCFA's low CRNA conversion factors occurred for two reasons. First, there was a technical error in the fee schedule legislation. A two-step budget neutrality requirement forced HCFA to calculate the CRNA conversion factors using only the monies paid for CRNA services under Part A (which

represented only 65% of the total CRNA costs). Left out of the equation were the other 35% of costs of CRNAs who were physician-employed. Therefore, the interim CRNA fee schedule attempted to pay 100% of CRNAs with only 65% of the money that had paid out for CRNA services in the previous year. Second, HCFA admittedly undervalued CRNA services by not using the most current and accurate AANA data. This undervaluing problem was eventually corrected in the CRNA final fee schedule published on July 31, 1992, and financial corrections were made by HCFA. However, the only way to remedy the technical error in OBRA86 regarding physician-employed CRNA costs, that resulted in inequities in the 1989 interim fee schedule, was for AANA to return to the legislative arena to secure fair Medicare CRNA conversion factors.

When HCFA was developing the 1989 CRNA conversion factors, AANA had repeatedly contended that the average amount per unit that would have been paid under a cost-based system in 1989 for a non-medically directed CRNA was \$21.83; the average amount per unit for a medically directed CRNA was \$13.85. These \$21.83 and \$13.85 figures were the basis for the legislation in the 102nd Congress which sought a \$21.00 conversion factor for non-medically directed CRNAs and a \$14.00 conversion factor for medically directed CRNAs. AANA contended that the \$21/\$14 fee schedule would more fairly approximate what Medicare would have paid in 1989 if the CRNA Medicare direct reimbursement hadn't been enacted.

Congress agreed with AANA on the need to increase CRNA conversion factors. OBRA90 included statutorily-determined Medicare CRNA conversion factors, effective January 1, 1991. (See Appendix 7) While the original AANA-supported legislation in the 102nd Congress would have created a national Medicare CRNA payment rate of \$21 per unit for non-medically directed CRNAs and a \$14 per unit for medically directed CRNAs, our efforts were stymied by the severe budget deficit facing the nation. Congress was only willing to accept a fee schedule proposal that would reimburse non-medically directed CRNAs at the same level that anesthesiologists would be in 1996, at the end of the RBRVS transition. At that time, anesthesiologist services were estimated to be, on average, 18% overvalued. It was envisioned that the 1990 anesthesiologist average conversion factor of \$20.42 would be gradually decreased under RBRVS until in 1996 it would reach 82% of \$20.42, which is \$16.75.

Non-medically Directed CRNA Rates

Therefore, the non-medically directed CRNA conversion factors were set to begin in 1991 at \$15.50 and increase \$0.25 per year until they reached \$16.75 in 1996 (adjusted by geographic indices). The \$16.75 is the same rate that

anesthesiologists were predicted to receive in 1996.

1991 -	\$15.50
1992 -	\$15.75
1993 -	\$16.00
1994 -	\$16.25
1995 -	\$16.50
1996 -	\$16.75

Medically Directed CRNA Rates

The medically directed CRNA conversion factors were set at 70% of the non-medically directed CRNA conversion factors. Therefore, they would begin in 1991 at \$10.50 and increase \$0.25 per year until they reached \$11.70 in 1996 (adjusted by geographic indices).

1991 -	\$10.50
1992 -	\$10.75
1993 -	\$11.00
1994 -	\$11.25
1995 -	\$11.50
1996 -	\$11.70

When the CRNA rates under OBRA90 were created, no one envisioned that anesthesiologist services would eventually be viewed as 29% overvalued under RBRVS. The fact that anesthesiologist services were ultimately viewed as 29% overvalued, versus 18% as originally projected, is the reason that anesthesiologist conversion factors have declined so dramatically in recent years.

The fact that anesthesiologist rates have declined, however, does not diminish the fact that the CRNA increases under Medicare are justified by the fact that they are not higher than they would have been if CRNA services were still paid for under the hospital reasonable cost pass-through. Any attempt to utilize a snapshot of CRNA Medicare conversion factors for 1990-1992 as a way of legitimizing future CRNA payment cuts is a misrepresentation of the history of CRNA payment under Medicare. The higher OBRA90 CRNA conversion factors merely brought equity to CRNA Medicare payment, which had been underpaid since 1989.

The AANA fought very hard to secure fair direct CRNA reimbursement under Medicare. We have also consistently urged the Physician Payment Review Commission and Congress to establish a payment policy that determines the value of an anesthesia service and then pays that amount to whoever provides the service.



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STATEMENT OF THE AMERICAN COLLEGE OF RHEUMATOLOGY TO THE SUBCOMMITTEE ON HEALTH COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES FOR THE RECORD OF THE HEARING MARCH 25, 1993

RE: BUDGET ISSUES RELATING TO PAYMENT UNDER PART B OF THE MEDICARE PROGRAM FOR PHYSICIAN SERVICES

The American College of Rheumatology (ACR/the College) is pleased to submit a statement to the Subcommittee on Health, Committee on Ways and Means for the record of the March 25, 1993 hearing on budget issues relating to payment for physician services under Part B of the Medicare program. The College is committed to efforts to stimulate the economy and reduce the federal budget deficit.

The ACR is the professional organization of rheumatologists. It includes practicing physicians and research scientists who are dedicated to preventing disability, healing and eventually curing more than 100 types of arthritis and related disabling and sometimes fatal disorders of the joints, muscles, and bones.

Our comments will focus on three of the President's budget proposals which affect the Medicare Part B program. Specifically, the plans to (1) phase in a resource-based practice expense index for the Medicare Physician Fee Schedule (MFS); (2) reduce the Medicare conversion factor by 2 percentage points for all services except primary care; and (3) reduce the default formula for the Medicare Volume Performance Standards (MVPSs) and the conversion factor updates.

Resource-Based Practice Expenses (RBPEs)

The ACR has been a strong supporter of basing the practice expense component of the MFS on resources. We have always supported this in concept because we believe that basing payments on resources is the most equitable way to reimburse physicians.

The current historical charged based methodology for assigning practice expense relative value units to physician services continues to create inequities for primary care and other evaluation and management oriented physicians. Only 54 percent of the Medicare Physician Fee Schedule (the work component) is resource based. Practice expense (41 percent) and malpractice expense (5 percent) continue to be based on distorted historical charges. The effort to reform Medicare physician payment is only half finished.

While we therefore support efforts to move to a resource based practice expense index as quickly as possible, we are very concerned about the President's proposal in this area.

The President's Proposal on RBPE: Phase In and Reductions — The President's plan starts off with a good idea. It would phase in resource-based practice expenses beginning in 1997; although the actual method would need to be developed and more data collected before that time. This element of the President's proposal has been recommended to Congress by the Physician Payment Review Commission (PPRC) and we believe it is a step in the right direction. The President's plan, also however, calls for reductions in the current practice expense relative value units (RVUs) for certain services in 1994, 1995, and 1996, prior to the phase in of resource-based practice expenses.

Specifically, the President's proposal would "reduce the practice component...when it exceeds the value of the work component¹." The proposal "would reduce practice expenses in relation to the relative value work units by one-half of the difference between practice expense and physician work relative value units²."

When the practice expense value exceeds the work value for a particular service, we understand that the Administration is planning to reduce the practice expense RVU by 25 percent of the difference between the PE and work values in 1994; 50 percent of the original difference in 1995, and 75 percent of the original difference in 1996. This is the same as reducing the PE values by 25 percent of the original difference between work and PE each year for 1994, 1995, and 1996. The President's plan also sets a floor of 110 percent of the work amount. That is, the practice expense value cannot be reduced below 110 percent of the work RVU under the President's proposal. The savings from this plan is estimated at a little over \$2 billion over a four year period.

ACR's Concerns -- If the President's plan on resource based practice expenses is implemented as written, the College is very concerned that there won't be enough monies left in 1997 and beyond for sufficient redistribution to services with undervalued practice expenses including primary care, or that redistribution will never take place if future further cuts are sought at that time.

The College and many others have always supported the Resource-Based Relative Value Scale (RBRVS) which was used for the MFS because philosophically we thought it was a much more equitable way to pay physicians than via historical charges. Physicians supported this change because they understood that funds would be redistributed from overvalued surgical procedures to undervalued evaluation and management (EM) services. While this redistribution has occurred through the work component of the fee schedule, EM services and particularly primary care remain undervalued because of the historical charge based system for practice expenses.

Rheumatologists experience significantly higher practice costs as a percentage of income than most physicians because they are primarily office based, see fewer patients in day while providing lengthier visits, and for the most part cannot rely on better paid invasive surgical procedures or diagnostic testing to generate additional income to cover their overhead costs. According to Dr. Hsiao, the author of the RBRVS, it was reported that practice expenses for rheumatologists were 54 percent of their income -- the highest percentage of any other medical specialty studied.³

While we would like to see resource based practice expenses implemented in a budget neutral manner, we understand that medicine must do its part to contribute to reducing the federal budget deficit.

ACR's Suggested Alternative for Deficit Reduction --

Instead of only reducing the practice expense (PE) relative value units (RVUs) for services with higher PEs than physician work values (with a floor of 110 percent of the work amount) -
 - reduce PE values faster and deeper for overvalued services using the same or a similar method and at the same time increase PE values for undervalued evaluation and management services, particularly office visits; allowing the same level of savings as the President's current plan. This would clearly show Congress' commitment to encouraging primary care and would have the support of the primary care community.

Specifically, it could be done by:

1. **accelerating the transition.** For example, instead of reducing the practice expense RVUs for overvalued procedures by 25 percent each year, the RVUs could be reduced by 33 percent each year. Or, one could front load the reductions by taking 50 percent the first

¹ A Vision of Change for America, Executive Office of the President, Office of Management and Budget (February 17, 1993), pages 97-98.

² ibid.

³ "Relative Cost Differences Among Physicians' Specialty Practices," by Becker, Dunn, and Hsiao, JAMA, October 28, 1988, page 2400.

year and a little less each additional year (front loading would also probably save more money in the long-run, due to compounding).

2. **lowering the floor.** The current floor of 110 percent of the work RVU – the maximum amount that the practice expense RVU could be reduced under the President's plan – could be lowered further to 100 percent or 95 percent of the work value, for example.
3. **applying all the additional saving that would result from accelerating the transition and lowering the floor to increasing practice expense RVUs for office visits and other evaluation and management services.**
4. To make this a more acceptable proposal to the medical profession, Congress may want to consider asking the Physician Payment Review Commission to identify and publish a list of services that current available evidence suggests are overvalued and undervalued as an alternative to arbitrarily applying reductions to any service when the practice expense RVU exceeds the work RVU.
5. Also, if the President's proposed method is pursued, Congress may also want to consider asking HCFA to publish the list of services that would be affected and what the reductions (for overvalued services) and increases (for EM services, especially office visits) would look like when you set the floor or accelerate the transition differently each year from the proposed method. We have not been able to run these numbers ourselves.

We believe our suggested alternative proposal is a fair way to achieve the same amount of savings as the President's plan and at the same time show Congress' commitment to improving payments for primary care services, thus encouraging medical students and residents to enter into primary care.

Full Medicare Fee Schedule Increase for Primary Care Services

The College fully supports the Administration's plan to exempt primary care from the reductions proposed for all other physician services. The President's proposal would reduce the Medicare conversion factor by two percent for all services except primary care (which in the past has been defined in the Medicare statute as office, nursing home, and home visits). If these reductions are taken at the same time the Medicare update is provided based on the current MVPSPs (which we understand is the Administration's intent), this proposal would in effect provide primary care with a full conversion factor update while reducing the amount of the update for all other services.

This would represent the first time in three years that primary care has received an update equal to inflation. By contrast, the 1993 update for primary care services was only 0.8 percent, compared to 3.1 percent for surgery – the exact opposite of what should have been done to avert a crisis in primary care.

The President's plan appears to recognize that if cuts in Medicare are required, they should be targeted toward higher-paid services and the specialties that provide them rather than toward primary care. As objections are raised by some to other Medicare cuts, the primary care update could be at risk of being reduced. We ask you to oppose such measures to safeguard primary care.

Reduction In the Defaults for the Medicare Volume Performance Standards and Updates

The purpose of the President's proposal in this area is to reduce the amount of increases in physician fees in future years. The plan would reduce the Medicare Volume Performance Standard (MVPS) default formula and the default update for Medicare payments to physicians. **Unless a special provision is provided for primary care, this proposal would inadvertently negatively impact on primary care services.**

Rather than lowering the default MVPSPs for both surgery and nonsurgery, the College recommends that a separate and higher MVPS be provided for primary care and other evaluation and management services, even if that requires a greater reduction in the MVPS for all other services to maintain the intended savings. This recommendation is for the default alone, as the

College would prefer the Congress to act each year with respect to a primary care update; and that the conversion factor update for all evaluation and management services be determined outside the MVPS framework. This preferred approach has the support of the Physician Payment Review Commission.

Summary

The American College of Rheumatology:

1. supports the concept of phasing in a resource-based practice cost methodology for the Medicare Fee Schedule, but believes that the practice expense relative value units (RVUs) for visit services that are now too low should be increased, rather than just lowering the overpriced practice expense RVUs for procedures. The College has offered an alternative proposal (detailed above) which could achieve the same level of savings as the President's plan, while at the same providing an incentive to primary care.
2. supports the Administration's proposal to provide the full Medicare Fee Schedule increase (equal to inflation) to primary care services. This primary care update should not be reduced to achieve budget savings elsewhere. Efforts to reduce the deficit should be directed at higher-paid services and the specialties that provide them.
3. recommends that a separate and higher Medicare Volume Performance Standard (MVPS) be given to all evaluation and management services including primary care under the default formula even if that requires a greater reduction in the MVPS for all other services to maintain the intended savings. Instead of allowing the default to kick-in, the College would prefer that Congress act each year to set the primary care update and that the amount be determined outside the MVPS framework consistent with health policy goals of providing incentives to primary care.

The American College of Rheumatology is pleased to share our views with this committee on the President's Medicare budget proposals. We believe that the Congress and the Administration want to support and encourage primary care even in this age of budget deficit reduction. Our recommendations would do just that.

TESTIMONY OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

The American Physical Therapy Association (APTA), which represents over 57,000 physical therapists, physical therapist assistants and students of physical therapy, commends the Subcommittee for holding this hearing and appreciates the opportunity to submit this testimony.

Physical therapists are affected by a number of provisions in the President's Budget Proposal and in other health care legislation which will be before the Committee as part of any Reconciliation package. Our comments include:

- support for the provision to ban physician ownership and referral of physical therapy services;
- support for legislation to eliminate Medicare's \$750 annual limit on physical therapy services provided by physical therapists in independent practice; and
- modification of language in the Miscellaneous and Technical Medicare Amendments Act of 1993 to allow greater provider participation in the development of pediatric relative value units.

Physical Self Referral Ban

The APTA supports President Clinton's inclusion of a physical self referral ban in his Budget Proposal. However, we believe that the provision does not go far enough because it will permit physicians to skirt the law by converting joint venture operations into employer/employee relationships.

The excess cost to our health care system associated with physicians being permitted to own and self refer patients to physical therapists, laboratories, radiological facilities, pharmacies and other services has been well documented.

In 1989, the Florida legislature mandated that State's Health Care Cost Containment Board examine the impact of joint ventures in health care on the cost of services, quality of services and access to services in Florida. Physical therapy services were surveyed in two settings: free-standing physical therapy facilities and comprehensive rehabilitation centers that provide physical therapy services. The findings were dramatic.

Physician-owned physical therapy facilities provided 43% more visits per patient than did non-joint-venture physical therapy facilities, generating approximately 31% more revenue per patient in joint-venture facilities than in non-joint-venture facilities. At comprehensive rehabilitation facilities, 35% more physical therapy visits were provided per patient in joint-venture facilities, generating approximately 10% more revenue per patient than in non-joint-venture facilities.

Equally important, the Florida study found that quality of care in joint-venture facilities was lower than in non-joint-venture facilities, and that joint-venture facilities did not increase access to services. In fact, the non-joint-venture facilities offered increased access to a wider range of clients. (Higher quality of care and increased access to services are often cited as rationales to defend joint ventures.)

Subsequent to the study conducted in the State of Florida, the Center for Health Policy Studies estimated the impact of physician joint ventures on medical care costs in Florida. This was done for three categories of services: imaging services (MRI and CAT Scan tests), clinical laboratory services and physical therapy services. Estimates for 1991 were developed based on findings from an analysis of Medicare claims data, results from the report by the Florida Health Care Cost Containment Board, "Joint Ventures Among Health Care providers in Florida" and from other sources. The estimated 1991 cost impact of physical joint ventures for these services in Florida are:

• Imaging Services (MRI tests and CAT Scans) (74% of MRI costs, 16% of CAT Scan Costs)	\$322.9 million
• Clinical Laboratory Tests (16.3% of clinical lab costs)	\$167.0 million
• Physical Therapy Services (2.4% of physical therapy costs)	\$10.9 million
TOTAL	\$500.8 million

The cost estimates for clinical laboratory and physical therapy services likely understate the true figures as only additional costs for users of these services were estimated. The incentives for physicians to refer to joint venture facilities likely also resulted in an increase in the number of users, the cost impact of which is not included in the estimates.

Spurred on by the findings of the Florida study, William M. Mercer, Inc. analyzed spending under California's mammoth Workers' Compensation program which will spend an estimated \$3.6 billion for medical care in 1992.

The Mercer study found that if an injured worker received initial treatment from a provider with an ownership interest in physical therapy services, that patient received a referral to physical therapy 66% of the time. If, on the other hand, the injured worker received initial treatment from a provider with no ownership interest in physical therapy, the patient was referred to physical therapy 32% of the time.

The study concludes that the added incentive for investing physicians to refer to physical therapy generates approximately \$233 million per year in services delivered for economic rather than clinical reasons.

While the President's proposal is a good first step, it contains a loophole which would allow physicians to skirt the intent of the law. The provision would still allow physicians to convert and continue to own physical therapy clinics where the health care staff are employees. This loophole would allow financial interest to remain in the referral process.

The APTA recommends that legislation be enacted to ban this practice of physician self referral to services to which they control access either as a matter of law or third party reimbursement policy. As the law is currently written, physicians are encouraged to offer through their employees the very services which other nonphysician practitioners are licensed by the States to provide but for which a physician's referral is required.

Consequently, if physicians are prohibited from investing in these services, such as physical therapy, but encouraged to offer them through their employees, a significant part of the problem will still remain. The situation will become that those physical therapists who are unwilling to become employees of referring physicians will simply not receive physician referrals and will, therefore, be precluded from providing the services they are licensed to provide.

We urge that Congress repeal Section 1128B(b)(3)(B) of the Social Security Act. This provision of the law protects these very arrangements from being categorized as fraud and abuse situations.

MEDICARE'S \$750 ANNUAL LIMIT ON PHYSICAL THERAPY SERVICES

Legislation will shortly be before this Subcommittee to eliminate Medicare's \$750 annual limit on physical therapy services that a beneficiary can receive from a physical therapist in independent practice (PTIP). This arbitrary limit is a redundant and ineffective means of utilization control and cost containment because several Medicare requirements already provide adequate protection and control.

Current Medicare coverage guidelines ensure the medical necessity of treatment by requiring that physical and occupational therapy services provided to a beneficiary:

- 1) be prescribed by a physician;
- 2) be furnished under a written plan of treatment approved in writing by the beneficiary's physician (the plan must relate the type, amount, frequency and duration of the therapy services and indicate the anticipated goals of treatment. Any changes in the plan of treatment must be approved by the physician); and
- 3) the beneficiary's physician must review the plan of treatment and recertify the patient's continuing need for therapy services at least every 30 days.

Additionally, the Health Care Financing Administration (HCFA), under the mandate of the Omnibus Budget Reconciliation Act of 1989 (PL 101-239), has placed the services of PTIPs under the physician fee schedule and volume performance standards. This measure controls payment for therapy services by a fee schedule; and overall volume of services are subject to volume performance standards.

Under current Medicare law, there is no limit to physical therapy services when they are provided either in a physician's office or in other provider settings. Medicare only limits coverage for services provided by PTIPs. When a patient who receives services from a PTIP reaches his or her limit, the

patient must either stop treatment, change to a therapist in another provider setting, or pay for these services out-of-pocket. Not only is it a burden for older and disabled Americans to change providers, but for those Medicare patients who live in areas where there is a shortage of health care providers such as rural areas, a physical therapist in another setting may be unavailable. Medical necessity and cost containment are ensured by the provisions mentioned above; not by an arbitrary limit of \$750. This limit merely disrupts necessary treatment of Medicare beneficiaries.

In the last Congress, Representative Bill Richardson (D-NM) and Senator John Chaffee (R-RI), along with 62 of their colleagues sponsored legislation to eliminate the \$750 limit. They are preparing to reintroduce this legislation into their respective bodies in the very near future. The APTA asks the Subcommittee to end this burden on older and disabled Americans by rapidly passing this legislation.

EXPAND PROVIDER INVOLVEMENT IN PEDIATRIC RBRVS DEVELOPMENT

The APTA believes that the wording of Section 206 of the Miscellaneous and Technical Medicare Amendments Act of 1993 (H.R. 21) needs to be modified. Section 206 directs the Secretary of Health and Human Services to explore development of a Resource Based Relative Value System (RBRVS) for pediatric services in consultation "with appropriate organizations representing pediatricians and other physicians."

This provision should be amended to ensure that not only physicians, but all health care groups who would be affected by a pediatric RBRVS system are included in the development of such a system.

The APTA supports the development of pediatric resource based relative value units (RBRVUs) because of the inherent differences in the way services are provided to pediatric and adult populations. Pediatric physical therapists deliver a wide range of services to children in schools, homes, private offices, and other community settings. We can be a major resource in the development of physical therapy RBRVUs.

Our concern about being excluded from this process is well founded. HCFA developed RBRVUs for physical medicine codes in the Medicare physician fee schedule with no input from physical therapists. The research team contracted by HCFA decided to solely rely on physician input. The result was a coding system which satisfied neither HCFA nor physical therapists in independent practice, who are required to bill under the Medicare fee schedule. The RBRVUs which were developed were so inaccurate that they were eventually rejected by HCFA. HCFA and the APTA are currently working to develop a coding system which reflects the full scope of physical therapy services and contains equitable RBRVUs. This could have been avoided if we were initially included in the process.

Because any system of codes and values for pediatric services extends beyond physicians to physical therapists as well as other nonphysician providers, the APTA strongly requests that Section 206 be amended by striking "physicians" in the last sentence (page 45, line 24 of H.R. 21) and replacing it with "health care providers."

The APTA appreciates the opportunity to provide this testimony and we are willing to work with the Subcommittee on these and other issues of mutual concern.

STATEMENT OF THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY

The American Society of Clinical Oncology (ASCO) is the national society representing physicians who specialize in the treatment of cancer. ASCO is submitting this statement in response to the Administration's budget proposals regarding Medicare payment for physician services and clinical laboratory tests and regarding prohibitions on self-referral.

Laboratory Payment Rates

Under current law, the same Medicare fee schedules that apply to large clinical laboratories also apply to laboratory tests performed by physicians in their own offices. The President's proposals include two reductions of the payment rates for laboratory tests. Whatever their appropriateness is for large commercial laboratories, these reductions should not be applied to tests performed in physician office laboratories.

One of the President's proposals would limit the fee schedule to 76 percent of the median of all fees, as opposed to the current maximum of 88 percent. This proposal is based on a 1991 report of the General Accounting Office, which recommended reducing Medicare payments to large clinical laboratories because they are making substantial profits on their Medicare business that offset the discounts they are giving to other purchasers.^{1/}

The GAO's study did not examine the costs of conducting laboratory tests in small commercial laboratories, much less physician offices. The study's focus was exclusively on the profit margins of the largest operations. Indeed, the GAO report admitted that some small laboratories could not simply reduce their profit margins but "would face losses" as a result of a reduction and would have to "improve their level of efficiency by reducing costs or leave the business."^{2/}

If small commercial labs could not survive under the proposal, what will become of physician office laboratories?

Oncologists depend on their office laboratories to provide appropriate patient care. In particular, blood counts and blood chemistries are necessary in conjunction with chemotherapy to determine whether the patient can tolerate additional chemotherapy and, if so, the appropriate dosage levels. These tests could not be transferred to outside laboratories without major inconvenience to patients and disruption of medical treatment.

Since the GAO's findings about overpayment to clinical laboratories referred only to large clinical laboratories, any reduction in the fee schedule to implement that recommendation should not be extended to physician office laboratories. Maintenance of adequate payment levels for laboratory work in physician offices is essential.

The second Administration proposal relating to laboratory payments would permanently extend the 2 percent laboratory update factor. Under current law, the update factor is scheduled to be increased in 1994 from 2 percent to the amount of the increase in the Consumer Price Index (CPI). The Administration's rationale for this restriction is the same GAO report on the profits of large commercial laboratories. In the absence of information on the costs of laboratory services in physician offices, such services should be afforded the full CPI update amount.

1/ "MEDICARE: Payments for Clinical Laboratory Test Services Are Too High," GAO/HRD-91-59 (June 1991).

2/ Id. at 12.

Practice Expense Phase-In

Under current law the practice expense component of the Medicare physician fee schedule is not resource-based but is based on historical charges. The President has proposed a phase-in to a resource-based practice expense component beginning in 1997. In addition, the Administration's proposal includes reductions in the practice expense component prior to 1997 that would generate substantial budget savings.

ASCO supports a prompt change to a resource-based practice expense component. We believe that many of the current relative values substantially understate the practice expenses involved. This appears to be the case for chemotherapy administration services, for example, and many oncologists routinely incur losses as a result of the faulty relative values for these services. ASCO sees no reason to wait until 1997 to begin using a resource-based practice expense component, and we urge that the change be fully accomplished as soon as an appropriate methodology is developed.

ASCO strongly objects, however, to the proposal to reduce the practice expense components on an interim basis. While some of the practice expense components are undoubtedly too high, they cannot be identified until a resource-based methodology is developed. As a result, the proposed interim reductions will likely reduce some of the practice expense components that are already undervalued, such as those for chemotherapy administration services.

Instead of an uninformed interim reduction of the practice expense components, ASCO urges the expeditious development and implementation of fully resource-based practice expense components.

Prohibition Against Self-referral

Current law prohibits a physician from referring a patient for clinical laboratory services to an entity in which the physician has an ownership or investment interest. The law exempts services furnished by the physician or the physician's group practice. The Administration's proposal would extend the prohibition to additional services, such as physical and occupational therapy, durable medical equipment, and parenteral/enteral nutrition equipment and supplies.

If the prohibition on self-referral is extended to additional services, it is essential that the current exemption for services provided by a physician or the physician's group be extended to apply to any newly covered services. Oncologists are particularly concerned that their ability to supply patients with portable infusion pumps -- which are items of durable medical equipment -- not be frustrated. At present, oncologists may own a supply of pumps, which are rented to patients for the administration of chemotherapy agents or pain-killing medication. Since the pump must be filled in the physician's office, there could be a substantial inconvenience to patients if the oncologist cannot furnish the pump.

Physician Payment Update Factors

The Administration's program includes arbitrary reductions in the inflation update for physician services. For 1994, the update for services other than primary care services would be two percentage points below the normal inflation factor. For future years, the default volume performance standard and the default

update factor would be reduced so as to limit payments for physician services. ASCO objects to these reductions.

The proposed reductions are not based on sound analytical grounds but are intended simply to achieve Medicare savings. Medicare payment rates already lag behind typical payment rates from non-government payers. Further reductions are unfair to physicians. We urge that these across-the-board reductions not be adopted.

TESTIMONY OF THE ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

The Association of Freestanding Radiation Oncology Centers ("AFROC") is delighted to have the opportunity to submit this testimony with respect to the Medicare Part B provisions of the federal government's FY 1994 budget. AFROC is an association of over 150 freestanding radiation oncology centers located throughout the country. Freestanding radiation oncology centers are health care facilities organized and operated to provide high quality, cost-efficient radiation oncology services to patients in their communities outside the hospital setting. It is estimated that there are approximately 300 to 350 freestanding radiation oncology centers located throughout the country, most of which are owned by the radiation oncologists who provide professional services in the facilities. Freestanding radiation oncology centers are heavily dependent on Medicare reimbursement, since approximately 55 to 65% of patients treated by such centers are covered under the Medicare program.

AFROC's comments relate specifically to proposed reductions in Medicare payment for practice expenses and proposed restrictions on physician "self-referral" for radiation oncology services. Each of these issues is discussed separately below.

I. PROPOSED REDUCTIONS IN MEDICARE PAYMENT FOR PHYSICIANS' "PRACTICE EXPENSES."

The provision of radiation oncology services outside the hospital setting requires significant capital investment, and the ongoing operation of such centers entails high expenditures for specialized staff, equipment, equipment maintenance, and other "facility" costs. In effect, such costs are comparable to the "facility costs" incurred by hospital outpatient departments that provide the same services.

Such "facility" costs are not directly reimbursed by the Medicare program; rather, these "facility" costs are currently reimbursed as the "technical" component of radiation oncologists' fees, under Medicare's physician fee schedule. When the Health Care Financing Administration ("HCFA") implemented the physician fee schedule, it closely analyzed the technical component RVUs provided for radiation oncology services, at the request of AFROC and other concerned radiation oncology organizations. Specifically, HCFA analyzed two cost studies that were submitted by the industry (one of which was performed by AFROC) and concluded that, in fact, freestanding radiation oncology centers had been underreimbursed for the substantial "facility" costs involved in providing radiation oncology services in freestanding settings. As the result of its analysis, HCFA decided to adjust the technical component RVUs provided for radiation oncology services to more accurately represent the costs incurred by "efficiently operated" facilities. Thus, the technical component RVUs for radiation oncology services are among the only technical component RVUs that are specifically based upon the resource costs involved.

In its proposed budget, the Administration has suggested that practice expense RVUs for certain services be reduced to more accurately reflect the resource costs involved. AFROC respectfully requests that radiation oncology technical component services be exempt from any such reductions, since the technical component RVUs for these services have already been adjusted by HCFA to reflect the substantial resource costs involved in providing radiation oncology services in freestanding settings.

II. PHYSICIAN "SELF-REFERRAL."

The President's budget proposal also proposes to extend the current restrictions on clinical laboratory "self-referral" to a number of other services, including radiation therapy services. AFROC strongly believes that where referring physicians, such as medical oncologists and surgeons, have a financial interest in a radiation therapy facility, this financial interest presents a serious conflict of interest which may interfere with the referring physician's judgment concerning the most appropriate center for the provision of radiation oncology services. For this reason, AFROC strongly supports the extension of physician "self-referral" restrictions to providers of radiation therapy services.

However, great care should be taken to ensure that such legislation does not inadvertently preclude radiation oncologists from owning their own facilities. For example, some of the bills introduced to extend restrictions on physician "self-referral" to radiation oncology and other "designated health services," fail to make conforming changes in the physicians' office exception included in the legislation. If the physician "self-referral" restrictions currently applicable to clinical laboratories were to be extended to radiation oncology services without appropriate changes in the exception language, the legislation could be read to preclude radiation oncologists from owning their own office. AFROC does not believe that radiation oncologists' ownership of their own facilities raises the types of conflicts of interest issues raised by medical oncologist or surgeon ownership of these facilities, nor do we believe that the "self-referral" legislation was originally intended to preclude radiation oncologists from owning their own facilities. Accordingly, we request that any physician "self-referral" legislation include a specific exception for radiation oncologist-owned centers.

If you have any questions regarding this testimony or any other questions concerning AFROC, please do not hesitate to call AFROC's Washington counsel, Diane S. Millman, at (202) 778-8021.



Continental Medical Systems, Inc.TM

STATEMENT FOR HEARING ON MEDICARE PART B ISSUES

SUBCOMMITTEE ON HEALTH COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES

MARCH 25, 1993

Chairman Stark and Members of the Subcommittee:

We appreciate the opportunity to present our views and recommendations on Medicare Supplemental Medical Insurance (Part B) issues. Continental Medical Systems is the nation's largest diversified provider of comprehensive medical rehabilitative care. Our services include Part B multidisciplinary therapy and physician services.

For purposes of this hearing, we urge your action on three specific Part B issues:

- Require HCFA to use the most current data for reimbursement of physical and respiratory therapists;
- Correct an OBRA '90 provision about billing for services of substitute physicians ("locum tenens" services); and
- Reduce administrative delays in resolving appeals of coverage denials.

It should be noted that each of these actions is important for the current Medicare program, especially its beneficiary services and administration. These actions would be important for the transition to any national health program and would not foreclose any national health approaches.

Require HCFA to use the most current data for reimbursement of physical and respiratory therapists

Nursing homes, rehabilitation agencies, and other providers frequently provide physical and respiratory therapy to their patients "under arrangements" with contract therapists.

In 1972, Congress limited Medicare reimbursement for therapy services provided "under arrangements" to basically no more than what Medicare would pay if the therapist was on salary as an employee of the provider (plus employee benefit and service support costs).

The Congressional report language stated that the salary equivalency limits should be based on "timely and accurate" data. However, the limits currently applied by the Health Care Financing Administration (HCFA) are based on salary data that are more than 10 years old and employee benefit and related service costs that are about 20 years old.

Counterproductive consequences to Medicare patient services and program costs from suppressing salary equivalency ceilings include the following:

- Keeping patients from receiving the full level of therapy they need, resulting in hospital backlogs, longer stays, and multiple transfers;
- Frustrating objectives to upgrade the care standards of nursing facilities and to serve the increasingly "heavy care" needs of the Medicare patients;

- Worsening the difficulty of nursing facilities to recruit and retain therapists or meet their needs from contract arrangements; and
- Acting as an obstacle to attracting a sufficient supply of physical therapists.

This situation is similar to others for which Congress enacted more specific mandates for HCFA administration of reimbursement limits, notably action in 1989 and 1990 for skilled nursing facilities. Importantly, the approach of enacting more directive language in regard to existing provisions has not involved an estimate of increased Medicare costs.

We recommend that section 1861(v)(5) be amended to direct the Secretary to recalculate the salary equivalency limits using timely, accurate and relevant data and to update the limits at least every three years thereafter.

Correct a OBRA '90 provision about billing for services of substitute physicians ("locum tenens" services)

We want to emphasize the importance of a technical correction to a physician billing provision enacted in the 1990 Omnibus Budget Reconciliation Act. Congress passed corrective legislation as part of H.R. 11, the Revenue Act of 1992, which President Bush vetoed. The provision is now pending as section 208(b) of H.R. 21, the Miscellaneous and Technical Medicare Amendments, introduced by Committee Chairman Rostenkowski and Subcommittee Chairman Stark.

This issue involves the billing procedures for physicians who provide substitute or reciprocal coverage for another physician. Substitute, or locum tenens, coverage occurs when a physician needs to be away from their practices for an extended period of time, for such reasons as continuing medical education, vacation or illness. A substitute physician is physically present in the practice of the permanent physician, including being subject to the policies and procedures of the practice and supported by the permanent physician's office staff. In contrast, reciprocal coverage occurs when another physician in the community covers for a permanent physician over a weekend or other short periods.

In 1990, Congress tried to clarify the billing procedures for these situations. Unintentionally, the OBRA '90 provision addressed only reciprocal coverage services.

We recommend that the next legislative action on Medicare provisions address the situation of substitute coverage services, as proposed in section 208(b) of H.R. 21.

There is also a need to clarify a similar situation that results when hospitals, clinics or communities retain the services of a substitute physician while they are in the recruiting process. This longstanding and widespread practice may be the result of a physician's death, retirement, or moving from the community for other opportunities.

The hospital, community or clinic generally pays the locum tenens physician a fixed per diem as an independent contractor, rather than an employee. Because the departed physician may have billed under an individual provider identification number (PIN), the hospital, clinic or community may not have an established group reimbursement PIN to be reimbursed for the services of the substitute physician.

We recommend authority for the hospital, clinic or community to bill Medicare and Medicaid, rather than the locum tenens physician who is being paid a fixed fee-for-time amount.

Reduce administrative delays in resolving appeals of coverage denials

Despite periodic attempts to improve the claims adjudication process, any such progress is undermined by the ever-lengthening delays in claims resolution. In short, the increasing volume of appeals and complexity of the decision-making combine to deny justice to Medicare patients and their providers.

We recommend that the situation has gotten so protracted that a time limit should be placed on appeals so that coverage is provided unless the appeal is actually rejected.

Conclusion

In conclusion, we appreciate the opportunity to present the views and recommendations of Continental Medical Systems regarding some Medicare Part B issues. We look forward to working with you on their timely enactment.



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**STATEMENT OF THE
RENAL PHYSICIANS ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
FOR THE RECORD OF THE HEARING
MARCH 25, 1993**

**RE: BUDGET ISSUES RELATING TO PAYMENT
UNDER PART B OF THE MEDICARE PROGRAM
FOR PHYSICIAN SERVICES (AND END-STAGE RENAL DISEASE (ESRD) SERVICES)**

The Renal Physicians Association (RPA) is taking this opportunity to provide a statement to the House Ways and Means Subcommittee on Health for the record of the March 25, 1993 hearing on budget issues relating to payment for Medicare physician services.

RPA is the professional organization of nephrologists whose goals are to insure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease.

Our comments will focus on the President's budget proposals and related matters which affect Medicare Part B and End-Stage Renal Disease (ESRD) services.

Health Care Reform and Consideration of Benefits for Inclusion In a Standard Health Benefit Package

As you are well aware, the President's Health Task Force chaired by Hillary Rodham Clinton is in the process of developing a standard benefit package for all Americans. With health care reform closer now than ever, the RPA is very concerned that the standard (basic or comprehensive) benefit package offered in any health care reform proposal specifically include all medically necessary renal related services including dialysis and renal transplantation.

The Medicare End-Stage Renal Disease (ESRD) program covers almost 93 percent of ESRD patients or approximately 150,000 individuals. While this program should remain intact as part of health care reform¹, there are a growing number of individuals who are not eligible for the Medicare ESRD benefit but who need ESRD services². We believe it is therefore necessary to cover these individuals under the standard package. RPA would urge this committee to ensure that all Americans are covered for medically necessary renal related services including renal dialysis and transplantation either through the Medicare ESRD program or through a standard benefit package that all health plans or employers would have to provide.

Payment Reduction for Erythropoietin (EPO)

Erythropoietin or EPO is a pharmaceutical used by patients suffering from kidney failure to counter anemia by increasing the body's production of red blood cells. EPO has allowed many dialysis patients to return to work and/or to lead more normal and fuller lives. Nephrologists, dialysis

¹ Although an assessment of the Medicare ESRD program within a new health care system should follow, the program could now serve as a model for health care reform. With prospective capitated payments for dialysis related physician services and treatments, the ESRD program is a model of cost effective managed care. In fact, according to HCFA's own data, per patient costs have decreased over time. This virtual single payer system (for a specific disease) has contained costs, expanded access to quality care and lengthened life expectancy.

² Kidney Failure and the Federal Government, Institute of Medicine (1991).

facilities, hospitals, and patients all need to purchase this drug because of medical need in the various settings in which this drug is administered.

Under the President's proposal as well as HR 21, Medicare payments for EPO would be reduced from \$11 to \$10 per 1,000 units. While we understand that this payment reduction is directed at the drug's manufacturer, RPA is concerned that this reduction not be passed on to patients and providers in the form of higher prices. Individual nephrologists and dialysis facilities are not in a position to negotiate rates with the manufacturer or suppliers, let alone patients. We must pay whatever the drug company or supplier charges.

Medicare expects nephrologists and dialysis facilities to pay for EPO from capitated rates which are already in need of desperate updates (see related discussion below on the need to increase the composite rate). These are the Monthly Capitated Payment (MCP) rate paid to nephrologists for treating dialysis patients in the outpatient setting (the subject of another paper), and the Composite Rate paid to dialysis facilities for outpatient maintenance dialysis treatments and related services (see below). While nephrologists and dialysis facilities pay for EPO to administer to patients, some patients do also purchase the drug fully out of pocket for home administration.

The issue of drug pricing and its impact on access is a complicated one. The RPA cannot claim that this proposed reduction would impede access to EPO, but we would urge this Committee at the very least to direct HCFA to closely monitor and annually report on access to EPO if this reduction in the EPO rate is enacted.

Extending and Altering the Medicare Secondary Payer Provision for ESRD Beneficiaries

The President's proposal calls for permanently extending the Medicare Secondary Payer (MSP) provision for ESRD patients from 12 to 18 months. This extension would otherwise expire in January 1996. Last year's Medicare package as included in HR 11 would have extended this provision to 24 months through 1995 for ESRD patients. During these initial periods, employer provided group health plans are expected to serve as primary payer for ESRD related medical expenses before Medicare would kick in.

The President's proposal would also make uniform all the other MSP provisions which affect not only ESRD beneficiaries, but also the aged and disabled. The plan would make all employer thresholds consistent with the aged provision which is 20 or more employees. That is, all employers with 20 or more employees with a group health insurance plan would be required to act as primary payer for its aged, disabled, and Medicare ESRD entitled employees for specified amounts of time. This requires a reduction in the disability provision from 100 to 20 employees and the creation of a 20 or more employee threshold for ESRD beneficiaries. Currently, all employer health plans, regardless of the number of employees, are required to serve as primary payers for beneficiaries who have become entitled to Medicare solely because of ESRD (as opposed to becoming entitled because of age or disability).

Lastly, the President would also eliminate the exemption from the MSP provision for individuals with ESRD who are also aged or disabled. Payments for these individuals would be treated the same as with payment for beneficiaries entitled to Medicare solely because of ESRD.

A recent interim General Accounting Office (GAO) report³ which studied the effects of the OBRA '90 ESRD MSP extension from 12 to 18 months, showed that the extension appeared to have negatively affected some beneficiaries' or their spouses' access to and retention of employment or employer health insurance. Although the numbers are relatively small this is cause for concern especially since the sample size was limited. A broader study should be conducted before Congress decides to make this extension permanent. In addition, the GAO's study of the effects of this provision is not completed. The GAO has yet to report on beneficiary out of pocket expenses and other issues, expected to be completed in January 1995.

Since we do not know yet what President Clinton's health care reform proposal will look like, it is difficult to speculate on how this provision will affect ESRD patients under a new health care

³ Medicare: Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans, United States General Accounting Office Report to Congressional Committees (December 1992).

system. ESRD patient and spousal access to health insurance (and job discrimination) is an issue that should be analyzed within the context of the President's health reform plan.

Extending the Physician Ownership and Referral Ban

President Clinton's economic package would extend the current ban on Medicare physician ownership and referral to outside clinical laboratories to other services including: physical and occupational therapy; radiology and other diagnostics; radiation therapy; durable medical equipment, and parenteral/enteral nutrition equipment and supplies. There have been similar proposals by Congressman Stark and others to also extend the current ban.

RPA is fully supportive of efforts to eliminate unethical referral arrangements by physicians. Although the President's provision in this area does not include renal dialysis facilities, RPA would like to ensure that any bill passed by the Congress in this area exclude nephrologist owned renal dialysis facilities because dialysis centers are an extension of the nephrologist's medical practice. This is clearly recognized within the medical community. Unlike most referral facilities, dialysis provides a therapeutic service and is not used for diagnostic purposes. Dialysis facilities only serve patients with irreversible kidney failure who must receive dialysis to maintain their lives. Dialysis is not an elective procedure and its medical necessity cannot be questioned.

Legislation which would blanketly ban self referral arrangements by physicians should explicitly exclude renal dialysis facilities. The following legislative language is suggested by the RPA:

Nonreferrals. The following shall not constitute a referral by a referring physician: a referral by a physician, or by a member of his or her group, to a renal dialysis provider in conjunction with a renal dialysis procedure performed under the supervision of the physician or by a member of his or her group.

Increasing the Composite Rate Paid to Dialysis Facilities

The Prospective Payment Assessment Commission (ProPAC) has recommended to Congress that the composite rate for dialysis facilities be updated by 2.5 percent for FY 1994. The RPA fully supports this long overdue update and urges Congress to enact this recommendation. As you may know, the composite rate paid to renal dialysis facilities for outpatient maintenance dialysis treatments and related services under Medicare has essentially been either frozen or reduced since the rate was established in 1973 with the exception of a \$1 increase per dialysis treatment in 1991. Even with this \$1 increase in 1991, the composite rate has dropped over 60 percent in real dollars because of explicit freezes and rate reductions and the unadjusted effects of inflation⁴ since 1974.

It is true that there were some productivity increases in the 70s and part of the 80s which allowed many dialysis facilities to operate successfully with the established rate, but reports about jeopardizing quality of care under these real dollar decreasing rates, especially from such notable sources as the Institute of Medicine⁵, is cause for alarm.

While there is not as much available and reliable data upon which to make a decision in this area as some would like, it is clear that some update is called for. A 2.5 percent increase in the composite rate as recommended by the ProPAC would at least provide in part for inflation and the extra costs associated with EPO, and the new regulatory burdens of CLIA, OSHA and ADA. With these extra costs and the fact that the rate has not been evaluated or updated in 20 years (with the exception of the \$1 dollar per treatment increase in 1991), a 2.5 percent increase is modest in any terms.

RPA's concerns about the quality of patient care is number one on our agenda. We are involved in practice guidelines research and development and are working with the Agency for Health Care

⁴ See Kidney Failure and the Federal Government, Institute of Medicine (1991); and Committee on Ways and Means, U.S. House of Representatives, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means (aka: the Green Book), (1992 Edition).

⁵ ibid.

Policy and Research (AHCPR) and the National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDK). Our efforts are also integrally connected with the U.S. Renal Disease Data System also known as the ESRD Patient Registry. A 2.5 percent update in the composite rate, as recommended by ProPAC, would certainly help renal dialysis facilities to maintain (and possibly improve) the quality of care provided to ESRD beneficiaries.

Reduction In the Medicare Volume Performance Standard and Update Default Formula

The purpose of the President's proposal in this area is to reduce the amount of increases in physician fees in future years. The plan would reduce the Medicare Volume Performance Standard (MVPS) default formula and the default update for Medicare payments to physicians.

RPA supports the need to amend the VPS formula established by Congress in OBRA's 89 and 90. Last year, the RPA urged Congress to preclude an almost four times higher and separate update for surgery than for non-surgery including primary care that would occur under the default formula. Unfortunately, Congress adjourned without taking any action to prevent this higher update for surgery from going into effect in 1993. The result is, unless Congress acts to correct the problem now, surgical services will permanently have a higher dollar conversion factor update than non-surgical services including primary care visits and other evaluation and management services.

The President's proposal provides an opportunity to correct this flaw. Instead of lowering the default VPS equally for all services, as the President's proposal would do, RPA would urge Congress to either support a single VPS for all services, or create a separate and higher VPS for EM services and a higher default update for primary care services including office, nursing home, and home visits.

The Physician Payment Review Commission, in its upcoming report to Congress will be recommending a similar approach. If separate VPSs are to be maintained says the PPRC, then EM services should be given improved treatment by being placed under their own VPS.

Exempting Primary Care From Any Reductions In Physician Fees In 1994

RPA fully supports the Administration's plan to exempt primary care from the reductions proposed for all other physician services. The President's proposal would reduce the current law Medicare conversion factor by two percent for all services except primary care. If these reductions are taken at the same time the Medicare updates provided based on the current MVPSS (which we understand is the Administration's intent), this proposal would in effect provide primary care with a full conversion factor update while reducing the amount of the update for all other services.

While RPA is pleased with the Administration's efforts to protect primary care, it must be noted that because primary care is lumped in with non-surgery in the current law VPS, surgery may still receive a higher update than primary care services even under this approach proposed by the President (see related discussion on the altering the default VPS and update above). Nevertheless, the President's proposal would represent the first time in three years that primary care has received an update equal to inflation. By contrast, the 1993 update for primary care services was only 0.8 percent, compared to 3.1 percent for surgery – the exact opposite of what should have occurred to promote and encourage primary care.

The President's plan appears to recognize that if cuts in Medicare are required, they should not negatively impact on primary care services. RPA would urge Congress to uphold the President's approach by providing a full 1994 fee schedule update for primary care services, and to reject calls for an across the board reduction that will be presented under the guise of "fairness." Similarly, if Congress entertains the idea of delaying the update entirely for a period of six months, for example, keep in mind that such a delay continues to perpetuate the almost four times higher and separate update for surgery (than for non-surgery including primary care) that took place in 1993. In addition, if a delay in the update is sought (which is obviously not the preferred approach), it should be enacted only on the condition that primary care services receive the full update at the end of that period.

Resource-Based Practice Expenses for the Medicare Physician Fee Schedule

The Administration is proposing to begin phasing in a resource-based practice expense index for the Medicare Fee Schedule beginning in 1997. To cut the deficit, the proposal also calls for reductions in practice expense relative value for certain services in 1994, 1995, and 1996. According to the President's plan, practice expense values would be reduced for services if the practice expense value exceeded the work value for a particular service.

RPA supports the idea of a fully resource based relative value scale. However, we are troubled by this proposal for several reasons. First, the President's method to reduce practice expense values is completely arbitrary. Why would the fact of having a practice expense value greater than the work value suggest that the practice expense value is overvalued and should be reduced? Although this arbitrary method would move many practice expense values closer to where they would be under a resource-based practice expense index, some may be cut too deeply, and others may be cut entirely without cause or reason resulting in a skewed RBRVS.

Second, there is still research that needs to be done, data to be collected, and questions to be answered, before a decision on an appropriate methodology for a resource-based practice expense index can be made and implemented -- even the Physician Payment Review Commission and the Health Care Financing Administration would admit this. Third, RPA is concerned about disrupting the initial current phase in of the fee schedule which will not be completed until 1997.

Fourth, while we understand that physicians must do their share to contribute to reducing the federal budget deficit, we would feel somewhat betrayed if the RBRVS was used merely for budgetary reasons, disregarding its original intent: namely to redistribute payments away from overvalued procedures to under-valued services such as office visits. Office visits and other evaluation and management services have practice expense components which remain undervalued.

If Congress decides to pursue the President's plan in this area, then it would be wise to also devise a mechanism (equally arbitrary) whereby undervalued services including primary care would see increases in their practice expense values at the same time overvalued services received decreases. Otherwise, the RPA would recommend not to tinker with the RBRVS until such time as a sound methodology is developed and better data collected on resource based practice expenses. The PPRC believes that this will occur by 1997 and thus has recommended that resource-based practice expenses be implemented at that time.

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**BUDGET ISSUES RELATING TO PAYMENT
UNDER PART B OF THE MEDICARE
PROGRAM FOR CLINICAL LABORATORY
SERVICES, DURABLE MEDICAL EQUIPMENT,
PHYSICIAN OWNERSHIP AND REFERRAL AR-
RANGEMENTS, AND OTHER MEDICARE REC-
ONCILIATION ISSUES**

TUESDAY, APRIL 20, 1993

**HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, D.C.***

The subcommittee met, pursuant to call, at 1:30 p.m., in Room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
FRIDAY, MARCH 26, 1993

PRESS RELEASE #9
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
BUDGET ISSUES RELATING TO CLINICAL LABORATORY SERVICES, DURABLE
MEDICAL EQUIPMENT, PHYSICIAN OWNERSHIP AND REFERRAL ARRANGEMENTS,
AND OTHER MEDICARE RECONCILIATION ISSUES

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on budget issues relating to clinical laboratory services, durable medical equipment, physician ownership and referral arrangements, and other Medicare reconciliation issues.

This hearing will be held on Wednesday, April 14, 1993, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

The Subcommittee previously announced that the March 25, 1993, hearing on budget issues relating to Part B of the Medicare program was to include consideration of issues relating to clinical laboratory services and durable medical equipment. These issues will now be considered on April 14, 1993. The hearing scheduled for March 25, 1993, was focused solely on issues relating to physician services.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

On February 17, President Clinton announced his budget proposals for fiscal year 1994. The President's proposal includes recommendations which would affect payments to clinical laboratories and durable medical equipment suppliers under Part B of the Medicare program. The plan also includes Medicare secondary payor reforms, as well as a proposal to extend the current physician ownership and referral prohibitions to additional services beyond clinical laboratory services.

The Congressional Budget Office (CBO) has estimated that these proposals would reduce payments for laboratory services by \$4.2 billion and durable medical equipment by \$651 million over five years. In addition, CBO has estimated that the proposal would save \$350 million by extending the current physician ownership and referral ban to additional services and \$6 billion as a result of Medicare secondary payor reforms over a five-year period.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Wednesday, April 28, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

(MORE)

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will ~~not~~ be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

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* * * NOTICE - CHANGE IN SCHEDULE * * *

FOR IMMEDIATE RELEASE
MONDAY, APRIL 12, 1993

PRESS RELEASE #9-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A CHANGE IN SCHEDULE FOR THE HEARING
ON
BUDGET ISSUES RELATING TO PAYMENT UNDER
PART B OF THE MEDICARE PROGRAM FOR CLINICAL LABORATORY SERVICES
AND DURABLE MEDICAL EQUIPMENT

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the hearing on budget issues relating to payment under the Part B of the Medicare program for clinical laboratory services and durable medical equipment scheduled for April 14, 1993, has been rescheduled for April 20, 1993. This hearing will be held immediately following the hearing on physician ownership and referral arrangements scheduled for 10:00 a.m. in room B-318 Rayburn House Office Building. (See press release #11, dated April 12, 1993.)

All other details regarding the hearing focusing on budget reconciliation issues relating to clinical laboratory services and durable medical equipment remain the same. (See press release #9, dated March 26, 1993.)

* * * * *

Chairman STARK. We will complete the consideration today of issues related to the fiscal year 1994 budget. We previously focused on issues relating to part A and physician payment under part B of the Medicare program, and this hearing will consider issues relating to clinical laboratory services and durable medical equipment.

The administration's budget includes proposals that would reduce spending over the next 5 years by \$685 million for DME and \$2.8 billion for clinical lab services.

Before proceeding, I would normally recognize the distinguished Ranking Member, Mr. Thomas, for an opening statement, but if he chooses later to submit one, the record will remain open the customary 5 days, and we will be happy to insert his statement in the record.

We will begin with testimony from Mr. Alvin Salton of the American Association of Bioanalysts. He is president and director of the Community Medical Laboratory in Metuchen, N.J. He will be followed in a few minutes by Hope Foster for whom we have given a brief break and we will have Hope come to the witness table when she returns.

Mr. Salton, would you like to begin?

STATEMENT OF ALVIN M. SALTON, PRESIDENT AND DIRECTOR, COMMUNITY MEDICAL LABORATORY, METUCHEN, N.J., ON BEHALF OF AMERICAN ASSOCIATION OF BIOANALYSTS

Mr. SALTON. Mr. Chairman, members of the committee, it is a pleasure to appear before you today to present testimony regarding fiscal year 1994 budget.

My name is Alvin M. Salton, and I am president and director of Community Medical Laboratory in Metuchen, New Jersey. I am here on behalf of the American Association of Bioanalysts, an organization that represents independent community-based clinical laboratories across the country.

Since 1986, the fee schedule has been limited by a national cap, originally set at 115 percent of the median carrier rate. The administration is proposing to drop the cap from 88 to 76 percent and limit the annual fee schedule adjustment to 2 percent. These cuts are intended to reduce laboratory payments by \$240 million in fiscal year 1994.

These proposals have not been and will not be successful. They were tried by both the Reagan and the Bush administrations.

Medicare expenditures for laboratory services are determined by two variables, the reimbursement per test and the number of tests ordered. The Federal Government has controlled the first variable. The reimbursement rate per test has been cut dramatically during the past 8 years. The fee schedule rates for the 15 most commonly ordered tests are only 50 to 70 percent of the 1984 rates.

However, the Government has failed to take any effective steps to control the second variable, the volume of testing. Chart A, as you see over here on your left, developed by the HHS Office of Inspector General, dramatically illustrates this point. The bottom line on the chart represents the amount Medicare expected to spend based on fee schedule cuts. The top line represents actual spending.

This chart clearly shows that simply ratcheting down the fee schedule will not result in overall program savings. To control laboratory costs you must first focus on the volume of tests. This variable is determined by physicians. The current system allows physicians to order and profit from unnecessary tests. Steps should be taken to eliminate these adverse incentives.

We have the following recommendations.

First, Congress should enact the direct billing statute. It has become a common practice for physicians to request and receive discounts in laboratories for non-Medicare services. They profit by marking up these tests before billing their patients and consequently have a substantial incentive to order unnecessary tests. These excessive test ordering patterns carry over to the Medicare program.

Second, physicians should not be permitted to maintain a financial interest in any laboratory to which they refer patients. The Stark law applies only to Medicare referrals.

As the Inspector General pointed out in his October 1990 report, to be effective, initiatives which prohibit physician referrals should extend to all laboratory work and not simply apply to tests performed on Medicare and Medicaid patients.

According to the same 1990 OIG report, removing the financial incentive can only be done by prohibiting physician ownership and financial interest in any laboratory, including physician office laboratories.

Beginning in 1982, Nevada prohibited physicians from billing Medicaid for laboratory tests. The results of the Nevada experiment are startling. Ten years after the program was initiated the amount spent per recipient is still below the 1982 level.

The Nevada experience stands in marked contrast to Medicare and other State Medicaid programs. This success story is illustrated by Chart B, as you see also on your left.

The bottom line reflects the Nevada experience. The top lines on the chart reflect the experience of other States. In many States the cost per recipient has risen by as much as 600 percent.

Congress needs to enact appropriate measures to control utilization. The savings from these initiatives will far outstrip those associated with an across-the-board reduction in the fee schedule. For example, direct billing could easily save three to four times the amount proposed in the President's budget.

We recommend that any cuts be targeted on procedures where the Federal reimbursement rate is out of line with the actual cost or value of the test.

We would like to work with the committee to develop such a list. For example, we would support the following specific changes in lieu of an across-the-board cut.

One, eliminate reimbursement for waived tests. In 1991, the Federal Government spent \$61 million on tests classified in the clear waived category. These tests are by definition simple laboratory procedures that pose no reasonable risk of harm to the patient if performed incorrectly. Medicare should not pay physicians or laboratories for such procedures.

Calculation of LDL amounts: 1991 expenditures for LDL calculations totaled \$112 million. This is now an automated calculation.

Eliminate organ or disease-oriented panels. Medicare has historically reimbursed such organ or disease-related panels at rates much higher than most automated panels.

We recommend that these tests be reimbursed at the same rate as automated panels. These three targeted reductions will result in \$385 million in savings, a figure \$145 million higher than the figure included in the President's budget.

In recommending this alternative, we do not want to leave the committee with the impression that cuts in the fee schedule, whether they are targeted or across the board, will actually hold down over all laboratory expenditures without tough utilization control mechanisms, such as direct billing or prohibiting all self-referrals.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF THE AMERICAN ASSOCIATION OF BIOANALYSTS

PRESENTED TO THE

HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE

April 20, 1993

Mr. Chairman, Members of the Committee, it is a pleasure to appear before you today to present testimony regarding the FY 1994 budget. My name is Alvin M. Salton and I am the President and Director of Community Medical Laboratory in Metuchen, New Jersey. I am here on behalf of the American Association of Bioanalysts (AAB), an organization that represents independent community-based clinical laboratories across the country.

As you are aware, laboratories are reimbursed under a fee schedule. Since 1986, the fee schedule has been limited by a national cap. The cap was originally set at 115 percent of the median carrier rate but has since been reduced to 88 percent. The Administration is proposing to drop the cap to 76 percent and limit the annual fee schedule adjustment to 2 percent. These cuts are intended to reduce laboratory payments by \$240 million in FY 1994.

AAB recognizes the importance of controlling Medicare expenditures. However, these proposals have not been, and will not be, successful. They were tried by both the Reagan and the Bush Administrations, yet, total laboratory costs continue to rise.

Medicare expenditures for laboratory services are determined by two variables: the reimbursement per test and the number of tests ordered. The federal government has controlled the first variable. The reimbursement rate per test has been cut dramatically during the last eight years. A survey conducted in 1991 found that payments for the 15 most commonly ordered tests were only 50 to 70 percent of the 1984 rates. Few, if any, other areas of the Medicare program have been subjected to comparable real fee schedule reductions.

However, total Medicare program expenditures for laboratory tests have continued to grow. This is because the government has failed to take any effective steps to control the second variable--the volume of testing. Chart A, which was developed by the HHS Office of Inspector General, dramatically illustrates this point.

The bottom line represents the amount Medicare expected to spend. The top line represents actual spending. This chart clearly shows that simply ratcheting down the fee schedule will not result in overall program savings.

If you are serious about controlling laboratory costs, you must focus on the volume of tests. This variable is determined by physicians. Doctors most often order tests because they believe the tests are in the best medical interest of the patient. In many cases an early diagnostic test will permit prompt intervention and avoid more costly and invasive procedures. However, the current system also allows physicians to order and profit from unnecessary tests. Steps should be taken to eliminate these adverse incentives. We have the following recommendations:

- First, Congress should enact a direct billing statute. It has become a common practice for physicians to request and receive discounts from laboratories for non-Medicare services. They profit by marking up these tests before billing their patients and consequently have a substantial

incentive to order unnecessary tests. These excessive test-ordering patterns carry over to the Medicare program.

This problem could be corrected by passing legislation similar to S. 337 which was introduced by Jeff Bingaman (D-NM) and Howard Metzenbaum (D-OH). S. 337 extends the current Medicare direct billing requirement to private pay patients.

- Second, physicians should not be permitted to maintain a financial interest in any laboratory to which they refer patients. The Stark law applies only to Medicare referrals. As the Inspector General pointed out in his October 1990 report:

. . . to be effective initiatives which prohibit physician referrals should extend to all laboratory work and not simply apply to tests performed on Medicare and Medicaid patients. . . .

According to the same 1990 OIG report:

. . . removing the financial incentive [can] only be done by prohibiting physician ownership and financial interest in any laboratory, including physician office laboratories."

Beginning in 1982, Nevada prohibited physicians from billing Medicaid for laboratory tests. The results of the Nevada experiment are startling. Ten years after the program was initiated, the amount spent per recipient is still below the 1982 level. The Nevada experience stands in stark contrast to the federal Medicare and other state Medicaid programs. This success story is illustrated by Chart B. The bottom line reflects the Nevada experience. In contrast, the top lines reflect the experience of other state Medicaid programs which have not implemented similar restrictions.

If Congress is serious about controlling laboratory costs it needs to enact appropriate measures to control utilization. The savings from these initiatives will far outstrip those associated with an across the board reduction in the fee schedule. For example, direct billing could easily save three to four times the amounts recommended in the President' budget.

However, should you decide to proceed with any further reductions in the fee schedule, we recommend that these cuts be targeted on procedures where the federal reimbursement rate is most out of line with the actual cost or value of the test. We would like to work with the Committee to develop such a list. For example, we would recommend the following specific changes in lieu of an across-the-board cut:

1. Eliminate Reimbursement for Waived Tests. In 1991, the Federal government spent \$61 million on tests classified in the CLIA "waived" category. These tests are by definition simple laboratory procedures that pose no reasonable risk of harm to the patient if performed incorrectly. Medicare should not pay physicians or laboratories for such procedures. Estimated 1994 savings would be \$93 million.
2. Calculation of LDL Amounts. 1991 expenditures for LDL calculations totalled \$112 million. While this used to be an independent calculation, for most laboratories it is now automated. Estimated FY 1994 savings are \$155 million.

3. Eliminate Organ or Disease Oriented Panels. Medicare has historically reimbursed certain organ or disease related panels at rates much higher than most automated panels. With the evolution of automated technology there is no reason for this distinction. We recommend these tests be reimbursed at the same rate as other panels. Estimated FY 1994 savings would be \$137 million.

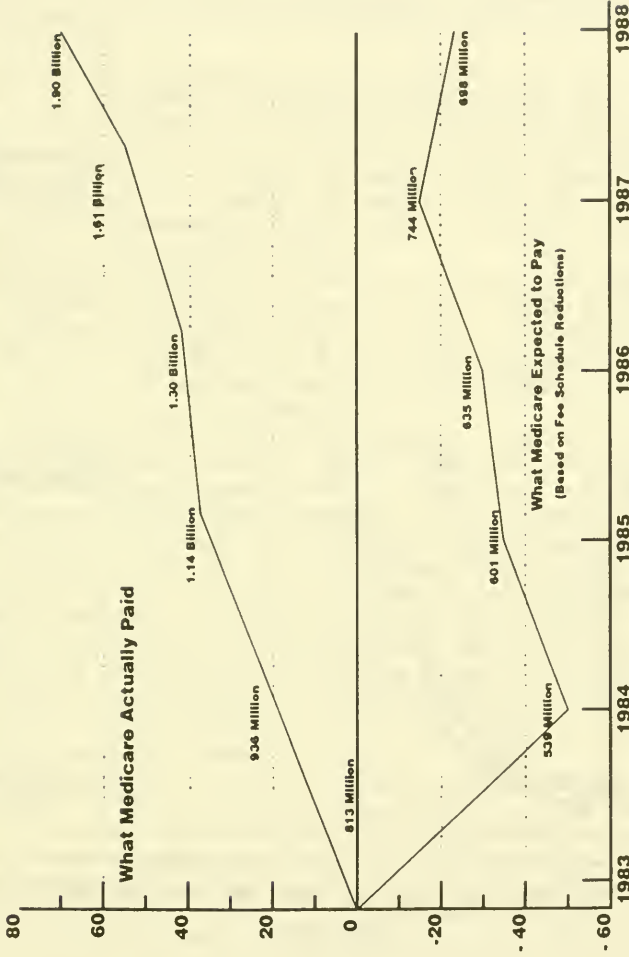
These targeted reductions would result in \$385 million in savings, a figure \$145 million higher than the \$240 million in FY 1994 laboratory reductions recommended in the President's Budget.

In recommending this alternative, we do not want to leave the Committee with the impression that cuts in the fee schedule, whether they are targeted or across-the-board will actually hold down overall laboratory expenditures without tough utilization control mechanisms such as direct billing and prohibiting all self-referrals.

Once again we are pleased to have had this opportunity to present our views and look forward to working with you in the upcoming weeks.

PERCENT CHANGE

Growth in Laboratory Expenditures Despite Reductions in Payment



Ensuring the appropriate use of Laboratory Services MHS Office of the Inspector General, October 1990

Chart A

Comparison of State Medicaid Laboratory Expenditures

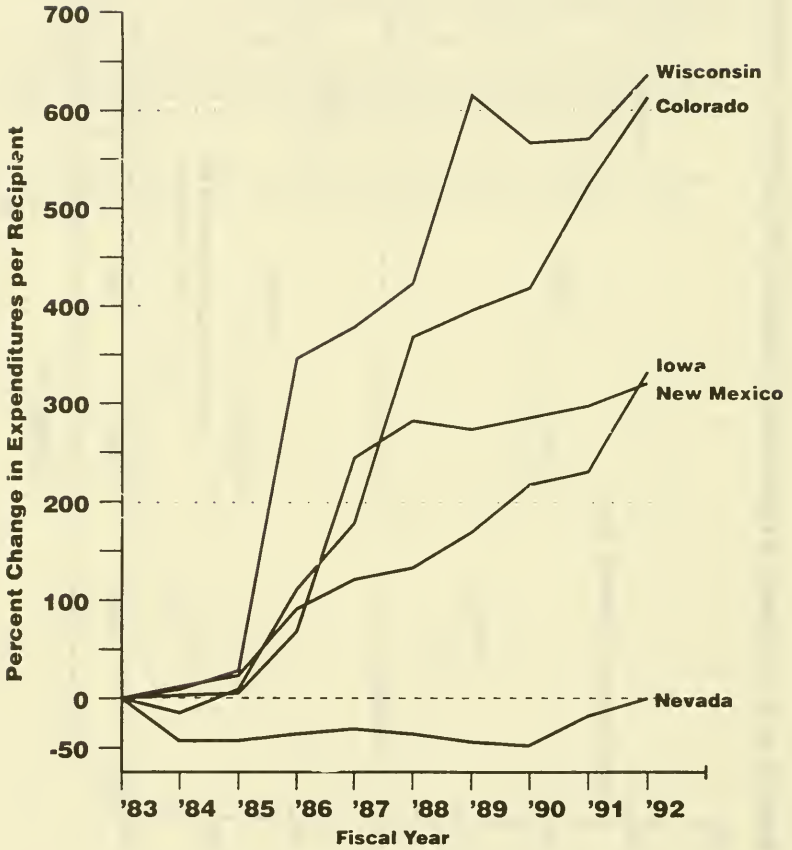


Chart B

**STATEMENT OF HOPE S. FOSTER, GENERAL COUNSEL,
AMERICAN CLINICAL LABORATORY ASSOCIATION**

Chairman STARK. Hope.

Ms. FOSTER. Thank you.

We appreciate the opportunity to share with you our reaction to the administration's fiscal year 1994 through 1998 budget proposal for laboratories.

As you know, Medicare uses median-based caps to limit reimbursement to clinical laboratories. Between 1986 and 1990, that cap was reduced from 115 to 88 percent of the fee schedule medians. The administration has now proposed lowering that cap to 76 percent, a cut that would make the cap 39 points lower than it was in 1986. Although we have not opposed past cuts, this proposed reduction will be too steep unless it comes with other reforms that I will discuss with you this afternoon.

Some statistics will illustrate our point: Since 1984, Congress has passed five different budget measures which, when totaled, called for \$3.5 billion in multiyear lab cuts. Medicare will only spend \$3.8 billion on lab testing this year. In its latest proposal, the administration calls for lab savings that total \$2.8 billion over the next 5 years. This cut is simply too large.

The administration's budget package also asks laboratories to contribute disproportionately to deficit reduction. According to the administration's most recent report, laboratories would shoulder over 18 percent of the part B provider savings proposed by the administration, even though these suppliers only constitute approximately 5 percent of part B expenditures. While such a request would be unfair at any time, it is particularly inequitable given the substantial reductions that labs have already sustained.

We are also troubled by the authority that the administration has requested to unilaterally change laboratory reimbursement rates based on technological and market factors. Congress has always made these decisions and you should continue doing so. We, therefore, oppose this request.

Please do not misunderstand. We fully recognize the need for deficit reduction and have worked closely with you in the past to achieve it. We anticipate doing so this year as well. We are, therefore, interested in a proposal that we have heard some of you may be considering, namely to reconcile the budget resolution by freezing Medicare payment rates. We would support this proposal because it would curb Medicare spending, it is equitable and it would make all health care providers equal contributors to curtailing the growth in outlays. We hope you will adopt a plan of this nature.

At the same time, we also know that many additional needed changes will be considered in the context of health care reform. One of them that we urge you to approve is a national direct billing mandate for all payers. An independent study appended to our written testimony found that enactment of such a law would cut non-Medicare expenditures between \$2.4 and \$3.2 billion a year for a 5-year savings of between \$12 and \$16 billion. Moreover, if adopted, additional reductions in Medicare spending for lab testing could be achieved.

Structural problems plague the lab marketplace and affect Medicare outlays. These problems arise because many physicians ask

for and receive large discounts for non-Medicare testing. A significant number of these physicians mark up the discounted prices by a substantial amount when they bill patients and third-party payers for the purchased test. As with other well-documented and publicized situations, like self-referral, when physicians have a financial stake in lab testing, utilization escalates thereby inflating Medicare expenditures. The independent study to which I just referred found that utilization of testing for Medicare beneficiaries was 6.5 percent higher in States that do not have direct billing. For non-Medicare patients, prices and utilization were substantially higher in non-direct-billing States than they were in direct-billing States. For example, in comparing experience in direct-billing versus non-direct-billing States, the study found that: one, charges for laboratory services were 8.4 to 9.6 percent higher in non-direct-billing States; two, per-enrollee laboratory utilization was 28.3 percent higher in non-direct-billing States; and three, lab charges per enrollee were 40.6 percent higher in non-direct-billing States.

The distortions which have led to these results also cause physicians to pay the least for testing, Medicare somewhat more, and other third parties to pay the most.

This structural problem demands a structural solution—implementation of a direct-billing mandate that would remove physicians from their role of “brokers” of lab testing. Under such a law, labs would be required to bill the party ultimately responsible for payment and would be prohibited from billing the test-ordering physician. Were such a law enacted, utilization would decline and labs could adopt a more rational pricing system that would benefit third-party payers, patients and Medicare. Such a law would also permit laboratories to absorb additional reductions in the amounts that Medicare pays, causing a shrinking of programmatic outlays. As our written testimony indicates, if direct billing were enacted, ACLA would not oppose a reduction of the Medicare cap to 76 percent as the administration has proposed. We, therefore, urge you to work for and support direct billing. It is a badly-needed reform. We would be happy to answer your questions.

Thank you.

[The prepared statement follows:]



1919 Pennsylvania Ave., Suite 800, Washington, D.C. 20006/(202) 887-1400

STATEMENT OF THE
AMERICAN CLINICAL LABORATORY ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE HOUSE WAYS AND MEANS COMMITTEE

April 20, 1993

The American Clinical Laboratory Association ("ACLA") is pleased to have this opportunity to comment on the Administration's budget proposals affecting reimbursement for clinical laboratory testing. ACLA is a trade association of federally regulated, independent clinical laboratories. ACLA represents national, regional, and local laboratories located throughout the United States. ACLA members will be significantly affected by the Administration's proposals for laboratories.

In the budget submitted to Congress, the new Administration has proposed reducing the national limitation amounts for laboratories from their current level of 88 percent of the fee schedule medians, to 76 percent of the medians. Further, the Administration has proposed limiting the update in the fee schedules to 2 percent, rather than raising them by the increase in the CPI, as was originally contemplated when the fee schedules were established. The update was set at 2 percent by OBRA '90 for 1991 through 1993, after which time it was to return to the full amount of the CPI. See §1833(h)(2)(A)(ii). Finally, the Administration has suggested allowing the Secretary of HHS to adjust Medicare payment rates to laboratories "to account for technological changes or other market factors."

For many years, ACLA has appeared before this Subcommittee to offer our views and our cooperation on ways to lower the federal deficit through equitable reductions in Medicare outlays for laboratory testing. In 1984, we assisted in the development of the Medicare fee schedule, which substantially reduced the amounts that Medicare paid to laboratories. In 1987, 1989, and 1990, we worked with Congress in suggesting other savings that could be achieved by lowering the national limitation amounts. As a result of the budget agreement reached in 1990, a proposal that ACLA supported, clinical laboratories will absorb additional cuts of \$1.2 billion between 1991 and 1996.^{1/}

ACLA has always participated in this process because we recognize our responsibility to help reduce the federal budget deficit. In addition, like other providers, we also recognize the need to assist in the on-going effort to reform the health care system. Thus, this year, we believe it is necessary to discuss not just our response to the new Administration's proposed reductions in laboratory reimbursement, but also our views on how laboratory services should be treated under health care reform. As discussed below, these two issues are inextricably linked, for ACLA can accept additional cuts in Medicare reimbursement, but only if the fundamental structural problems plaguing the laboratory market are corrected as part of health care reform.

In the past, ACLA has urged that changes be instituted in the industry through passage of a federal direct billing law, which would require that laboratories that perform testing bill

^{1/} Committee on Ways and Means, Overview of Entitlement Programs ("The Green Book") at 209 (1991).

the appropriate payor for that work. In view of the new cuts proposed by the Administration and the efforts to reform health care generally, it is imperative that direct billing now become a reality. Direct billing will result in a more efficient laboratory market that will ultimately benefit all payors, including Medicare. Further, an independent study discussed below shows that enactment of direct billing could reduce non-Medicare health care costs generally by between \$2.4 and \$3.2 billion a year. Such reductions are urgently needed to help fund other health care reforms. If direct billing is enacted, ACLA members would be better able to absorb the cuts in reimbursement that are being proposed. In addition, the enactment of direct billing would also allow laboratories to absorb reductions in reimbursement received from private payors, as detailed in the attached health reform proposal. (See Appendix 1.) Without the enactment of direct billing, additional Medicare cuts will simply force many laboratories to reduce services and could force some laboratories to close entirely, thereby reducing access to testing services.

In our testimony today, we would first like to give some information on the background of laboratory reimbursement and the need for change. Then, we will address the Administration's current proposals and detail our proposal for reform.

1. The Value of Laboratory Testing.

Laboratory testing is an important, life-saving and cost-containing health care tool, which permits the early detection and treatment of a variety of conditions. Laboratory testing is instrumental in the early diagnosis of diseases such as AIDS, Hepatitis and countless others. Other tests, such as therapeutic drug monitoring ("TDM") assays, are used routinely to track the effects of life-saving medications prescribed for cancer and other serious illnesses. Concern about coronary heart disease has caused an increased awareness of the need to perform regular cholesterol testing and related measurements of HDL and LDL. The early diagnosis and treatment permitted by appropriate testing ultimately saves money for all health care payors, including Medicare. Indeed, the greatest value of clinical laboratory testing is its ability to lead to the early diagnosis of disease and to prompt, cost-effective treatment.

Since 1984, laboratories, like many providers, have repeatedly had to confront reduced Medicare reimbursement. The caps on the fee schedules, which were initially set at 115 percent of the fee schedule medians, were subsequently reduced to 100 percent in 1988; to 93 percent in 1990; and then to 88 percent in 1991. At the same time, there have also been reductions in the CPI updates and freezes on other payments.

Appendix 2, which is attached to this testimony, shows the impact of these repeated reductions in reimbursement for clinical laboratory services. The five different budget bills enacted between 1984 and 1990 slashed clinical laboratory reimbursement by an estimated \$3.5 billion. The Administration's latest budget request would impose an additional \$3.8 billion in cuts between 1994 and 1997.

At the same time, the costs of laboratory testing have increased substantially. For example, as a result of the emergence of AIDS and Hepatitis B, laboratories now take additional precautions to protect workers from bloodborne pathogens, as required by the Occupational Safety and Health Administration, including paying for workers' vaccinations. In addition, the new requirements imposed by the Clinical Laboratory Improvement Amendments of 1988 ("CLIA'88") and other regulations, such as those related to medical waste removal and treatment, have further added to laboratory expenditures. ACLA does not argue with the need to protect workers, safeguard quality control

or protect the public health and our environment; nonetheless, implementing these requirements is expensive.

In addition, laboratory labor costs have also dramatically increased over the past five years. For example, a recent report by the American Society of Clinical Pathologists ("ASCP") shows that salaries for phlebotomists, the individuals who draw blood, have risen by almost 20 percent since 1990. Cytologist salaries grew by 17.4 percent for staff level positions and 14.4 percent for supervisory positions during that same period.

Such increasing costs, when coupled with further reductions in reimbursement, cannot help but affect the ability of laboratories to offer accessible, efficient, high quality laboratory testing.

2. The Need for Structural Change

In view of these increasing costs and reductions in reimbursement, laboratories are hesitant to agree readily to additional cuts in Medicare rates. However, ACLA could accept some cuts, if Congress also enacted other changes in the market. Enactment of a direct billing law would permit laboratories to accept such reductions, because it would result in a more equitable payment structure and, in addition, would ultimately save money for the entire health care system.

To understand the importance of direct billing, it is important to understand how the laboratory market works. Under the present system, physicians can request that laboratories bill them for testing that they order for their non-Medicare patients. Because laboratories cannot order testing themselves, the physician can also request--and receive--discounts from the laboratory providing this testing. The physician can then mark-up these tests when third parties and patients are billed. This system gives the doctor a financial interest in the testing that is ordered, comparable to that which exists in the case of self-referral. As a result, the current system creates incentives that can lead to increased use of laboratory testing. Because of the obvious concerns arising from this arrangement, Medicare requires the laboratory performing the testing to bill the Program directly. Most states, however, permit the laboratory to bill the physician for non-Medicare testing.

The current system results in cost-shifting because it forces laboratories to increase prices to other payors--to Medicare, to the extent possible, to third-party payors and to patients. Medicare has protected itself from such shifting to some extent through the enactment of the fee schedules and national limitation amounts. However, patients and private payors still end up paying increased prices, either because they bear the mark-up tacked on by the test-orderer or because laboratories are forced to offset physician discounts and reductions in Medicare reimbursement when they bill patients and third-party payors.

Reform of this system would allow laboratories to absorb the lower Medicare reimbursement proposed by the Administration because it would eliminate the inequities noted above. Under such a system, the laboratory that performed the testing would usually be required to bill for the testing. Enactment of such a provision would eliminate the incentives that currently lead to increased testing. Furthermore, because laboratories would no longer have to offset the discounts given to test-orderers, laboratories could afford to accept lower reimbursement from Medicare, private payors and patients.

In addition, the enactment of direct billing would result in a substantial savings to the health care system. An independent

study sponsored by ACLA demonstrates that such savings could be between \$2.4 and \$3.2 billion a year. The Center for Health Policy Studies ("CHPS") compared the experience of Medicare and Blue Cross/Blue Shield in direct billing and in non-direct billing states. The CHPS Report, a copy of which is attached as Appendix 3, found that laboratory prices and utilization were dramatically higher in non-direct billing states than in direct billing states. Among the findings of the study were the following:

- Charges for laboratory services were 8.4 to 9.6 percent higher in non-direct billing states than in direct billing states.
- Laboratory utilization per enrollee was higher in non-direct billing states than in direct billing states. For tests reimbursed by Medicare, utilization was 6.5 percent higher and for tests reimbursed by private payors--where incentives for overutilization are greatest--it was 28.3 percent higher.
- Laboratory charges per enrollee under private health insurance programs, a measurement that takes into account both utilization and price differences, were 40.6 percent higher in non-direct billing states.

The report concludes that if a national direct billing law were enacted, savings of between \$2.4 and \$3.2 billion per year could be achieved in health care expenditures, as a result of reduced utilization and lower prices.

Further, as detailed in the attached health reform proposal, if direct billing were enacted, ACLA would also be willing to accept a cap on non-Medicare reimbursement. Enactment of such a cap would have the effect of substantially lowering laboratory reimbursement in the private sector.

In short, enactment of direct billing would mean that Medicare, private payors and patients would all end up paying fairer prices. Laboratories could also afford to accept lower reimbursement from these payors. Finally, the health care system itself would save at least \$12 billion to \$16 billion over the next five years because of reduced laboratory utilization and lower prices. This savings figure does not take into account additional reductions in Medicare or the cap on private reimbursement envisioned by our proposals.

3. Response to the Administration's Proposal

With this background in mind, we now turn to a discussion of the Administration's proposal. The Administration has suggested reducing Medicare reimbursement for laboratories from 88 percent to 76 percent of the fee schedule medians, a figure that is derived from an industry report done by the GAO. ACLA believes that there are flaws in that report, and that it is inappropriate to base a major change in policy on its conclusions alone. Based on our review, it appears that the GAO may have substantially overstated the differences between what laboratories earn on Medicare and non-Medicare testing.

Nonetheless, as noted above, if direct billing were enacted, laboratories would be able to accept some additional cuts in reimbursement from Medicare. ACLA wishes to emphasize, however, that it is the efficiencies resulting from the enactment of direct billing that would permit laboratories to absorb such reductions. Without direct billing, these cuts will simply exacerbate the inequities of the current system and many laboratories, especially smaller laboratories and those serving

rural and underserved areas, will be unable to survive.

ACLA also could accept a cap on the update in the fee schedules in connection with direct billing, although we believe some adjustment should continue to be made to reflect rising costs faced by the industry. A failure to have some update would actually constitute an additional cut in laboratory reimbursement.

ACLA must object, however, to the Administration's proposed plan that would permit the Secretary to set rates based on changes in technology and market conditions. In the past, HHS and the Administration have submitted proposed changes in reimbursement to Congress, which then has decided whether or not to enact them. The Administration's proposal would not permit the Congress any involvement in the procedure by which payment levels for laboratory services are set, a dangerous precedent in the view of ACLA. If the Department determines that further changes in payment levels are necessary, it should propose such changes to Congress, just as the agency has always done in the past, and then permit Congress to determine whether, and how, to implement those changes.

ACLA has a number of other recommendations for health care reform in the laboratory industry. These include caps on reimbursement from private payors, limitations on the use of profiles, and the enactment of administrative simplification. These changes are discussed in ACLA's statement on health care reform, which is attached to this testimony.

ACLA appreciates the opportunity to appear before the Committee today and looks forward to working with the Congress and the Administration in creating a fairer market for clinical laboratory services.



1919 Pennsylvania Ave., Suite 800, Washington, D.C. 20006/(202) 887-1400

THE AMERICAN CLINICAL LABORATORY ASSOCIATION SUPPORTS HEALTH CARE REFORM

The American Clinical Laboratory Association ("ACLA") is an organization of federally-regulated, independent clinical laboratories, which represents national, regional and local laboratories located throughout the United States. Over 60 percent of the services furnished by independent clinical laboratories are supplied by ACLA members. These laboratory services play a vital role in the health care delivery system and offer a cost-effective method of diagnosing and monitoring a variety of illnesses and conditions.

ACLA recognizes that fundamental reform of the health care system is urgently needed and, therefore, is proposing a four-part plan to confront the problem of rising costs and increasing utilization of laboratory testing. The centerpiece of this plan is the enactment of a federal law requiring direct billing of laboratory services; i.e., a requirement that the laboratory bill the third-party payor or patient who is responsible for payment, rather than the physician requesting the tests. For the reasons discussed below, ACLA believes enactment of this simple provision would lower utilization, eliminate cost-shifting, and reduce laboratory costs to patients and third-party payors. *If ACLA's plan is enacted, ACLA estimates that it would result in a savings to the health care system of more than 16 billion dollars over the next five years.*

THE CURRENT SYSTEM DISTORTS THE MARKET

Under the present system, physicians can request that laboratories bill them for testing that they order for their non-Medicare patients. Because laboratories cannot order testing themselves, the physician is in the position where he or she can also request — and receive — discounts from the laboratory providing this testing. The physician can then mark-up these tests when third parties and patients are billed. This system gives the doctor a financial interest in the testing that is ordered, and creates incentives that can lead to increased testing. Because of the obvious concerns arising from this arrangement, Medicare requires the laboratory performing the testing to bill the program directly.

The current system also results in cost-shifting because it forces laboratories to increase prices to other payors: to Medicare, to the extent possible, to third-party payors and patients. Medicare has protected itself, to some extent, through the enactment of fee schedules and national limitation amounts. However, patients and third-party payors also end up paying increased prices, either because they bear the mark-up tacked on by the test-orderer, or because laboratories, when they bill patients and third-party payors, must offset physician discounts and reductions in Medicare reimbursement.

PART ONE: ENACT FEDERAL DIRECT BILLING LEGISLATION

Enactment of a federal direct billing law is the single most important part of reforming the present system. It is the one provision that allows achievement of all other goals. It is a simple provision mandating that laboratories performing the testing only bill the person or insurer responsible for payment. Such a provision is already included in S.337, a bill introduced this year by Senators Jeff Bingaman and Howard Metzenbaum. It could also easily be included in a prohibition on self-referral, to which this issue is closely related. Independent studies sponsored by ACLA demonstrate that enactment of a direct billing provision standing alone would reduce health care costs between \$2.4 and \$3.2 billion a year, as a result of lower prices and decreased utilization. This is a savings of at least \$12 billion over the next five years.

PART TWO: ENACT SIGNIFICANT COST-CONTAINMENT MEASURES

If a direct billing law is enacted, laboratories would be able to accept cuts in reimbursement from Medicare and private payors, and all payors will end up paying fairer prices. If direct billing is enacted, laboratories could accept lower reimbursement from Medicare. President Clinton has proposed lowering the national limitation amounts, which act to cap Medicare reimbursement for laboratories, from their current levels of 88 percent to 76 percent of the fee schedule medians. ACLA could accept this cut if it is accompanied by direct billing. This reduction is estimated to save approximately \$4.4 billion over five years. When these savings are added to the savings resulting from direct billing, the total package would reduce health care costs by at least \$16.4 billion over the next five years, and probably more.

Direct billing would also make it possible for ACLA members to absorb lower prices from private payors, as well. Along with direct billing, ACLA proposes a cap on laboratory payments, set at the actual median of the current Medicare laboratory fee schedules, as defined in Section 1833(h) of the Social Security Act. Enactment of such a provision would have the effect of substantially lowering laboratory reimbursement in the private sector. While it is impossible to calculate precisely how much such a provision would save, as competition could ultimately drive prices below this cap, ACLA believes the savings would be substantial, and would be in addition to the savings already discussed. Further, the combination of direct billing and fee caps will transfer the benefits of price and service competition from the physician to the ultimate payor, either the patient or the third-party payor.

ACLA wishes to emphasize, however, that it is the enactment of direct billing that allows laboratories to propose these cost containment measures. Because of the additional costs that are being imposed on laboratories due to new regulatory and quality control requirements, these additional payment reductions, in the absence of direct billing, will likely be offset by decreases in services and the closing of some facilities, resulting in reduced access to care.

PART THREE: ENCOURAGE MORE APPROPRIATE USE OF PROFILES

One factor that may have led to the increased utilization of testing services is the use of "test profiles." Profiles are a group of related tests that are packaged together. For example, a physician ordering tests for a patient with liver disease may order a "hepatic profile," a group of related tests used for patients known or suspected to have this condition. While profiles are a necessary and valuable tool, it has also been suggested that they may lead to increased testing. For example, in some instances, physicians may order the profile without understanding which tests are included in the package. ACLA believes a process should be established to develop standardized profiles and their components, and to modify them, as necessary, in the future. ACLA would be pleased to work with the Department of Health and Human Services and the various medical societies in developing a limited list of accepted profiles. ACLA also believes that laboratories should disclose to physicians the component tests included in each profile and their prices to third-parties.

PART FOUR: PROMOTE ADMINISTRATIVE EFFICIENCY

First, a system of administrative simplification should be enacted so that it is clear to all health care providers what medical and insurance information must be obtained from a patient. This is especially important for laboratories, which do not usually have direct contact with the patient and must rely on the physician to obtain this information. Second, the number of Medicare carriers processing laboratory claims should be reduced, preferably to a single, centralized carrier. Today, laboratories deal with over 50 different Medicare carriers, all of which have their own procedures and policies. Because laboratories often have testing facilities in many different states, several carriers usually have jurisdiction over each laboratory and sometimes even over a single claim. This system results in unnecessary duplication of effort and a waste of time and money.

EXPECTED SAVINGS FROM LABORATORY CUTS (in millions)

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	TOTALS
	(FISCAL YEAR)														
DEFRA '84 ^{1/} (established lab fee schedule)	40	240	300	380											960
COBRA '86 (established fee caps at 115% of the medians) ^{2/}			10	12	22	22	27	37							130
OBRA '87 (3 month freeze on fee schedules; reduction of caps to 100%; reduction in fees for automated tests; limited CPI update) ^{3/}					65	135	225								425
OBRA '89 (reduction in caps to 93%) ^{4/}							65	130	135	185	215				770
OBRA '90 (reduction in caps to 89%; limited CPI update) ^{5/}								90	185	270	325	365			1,235
NEW ADMINISTRATION PROPOSAL ^{6/}											420	800	1,110	1,500	3,830
TOTAL	40	240	310	392	87	157	337	257	340	435	960	1,165	1,110	1,500	7,350

^{1/} Background Material and Data on Programs Within The Jurisdiction Of The Committee on Ways and Means at 161 (1986).

^{2/} Background Material and Data on Programs Within The Jurisdiction Of The Committee on Ways and Means at 169 (1987).

^{3/} Background Material and Data on Programs Within The Jurisdiction Of The Committee on Ways and Means at 184 (1989).

^{4/} 1991 Green Book at 209 (1991).

^{5/} Id. at 230 (1991).

^{6/} Dept. of the Treasury (Feb. 17, 1993).

**IMPACT OF DIRECT BILLING REQUIREMENTS FOR LABORATORY
TESTS ON LABORATORY CHARGES, UTILIZATION AND COSTS**

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EXECUTIVE SUMMARY

The Center for Health Policy Studies (CHPS) has been asked to study the impact of the enactment of a national direct billing law for laboratory testing; i.e., a law requiring the laboratory that performs the testing also to bill for that testing. Such a requirement would eliminate the current practice which permits physicians to mark-up testing, other than Medicare testing, that they do not perform.

CHPS has determined that laboratory charges and utilization are higher in states that do not require direct billing. It appears likely that enactment of a national direct billing law could substantially reduce health care expenditures, by between \$2.4 and \$3.2 billion per year, due to the lower laboratory prices and reduced utilization of laboratory testing that would result from such a provision.

Under the current system, laboratories often contract with physicians to provide laboratory testing services. In most states, physicians can then mark up this testing when they bill third party payors and patients. This ability to mark up prices creates strong financial incentives for physicians to order additional testing, thereby increasing laboratory costs. The purpose of this study is to determine how a direct billing requirement affects laboratory prices and utilization.

CHPS has performed an analysis of Medicare and Blue Cross and Blue Shield claims experience, including laboratory prices (charges per test), utilization and total charges

per enrollee. CHPS determined that each of these measures is higher in states that did not require direct billing. The primary findings of the study are:

- Laboratory charges per test are higher in non-direct billing states than in direct billing states -- 8.4 to 9.6 percent higher.
- Laboratory utilization per enrollee is higher in non-direct billing states than in direct billing states. For tests reimbursed by Medicare, utilization is 6.5 percent higher. For tests reimbursed by private payors it is 28.3 percent higher.
- Laboratory charges per enrollee under private health insurance programs, which reflect both utilization and price differences, are 40.6 percent higher in non-direct billing states.

Therefore, it appears likely that if a national direct billing law were enacted, substantial savings could be achieved in health care expenditures, as a result of reduced utilization and lower prices. As noted above, CHPS estimates that these savings would be between 2.4 and 3.2 billion dollars a year.

IMPACT OF DIRECT BILLING REQUIREMENTS FOR LABORATORY TESTS ON LABORATORY CHARGES, UTILIZATION AND COSTS

INTRODUCTION

The purpose of this study conducted by the Center for Health Policy Studies (CHPS) is to investigate the impact of provider direct billing requirements for laboratory tests on charge levels, utilization and total costs for laboratory tests. If a cost impact is determined to exist, an additional study objective is to estimate potential cost savings if direct billing requirements were to be required for all payers in all states.

Since July, 1984, Medicare has not allowed physicians to bill Medicare for laboratory tests that were performed by other providers, e.g. physician billing for a test when the test was actually performed by an independent laboratory. In most states, there are no direct billing requirements for services paid for directly by the patient or through private health insurance. It is common practice in these states for laboratories to contract with physicians to provide laboratory testing services under monthly billing account arrangements. There is active price competition for physician accounts and prices offered are usually substantially below "retail laboratory prices" -- prices charged by physicians and laboratories to patients and private health insurers. Physicians typically bill and receive fees for laboratory tests which are well in excess of the prices they pay independent laboratories for the tests.¹ This ability to mark up prices for laboratory tests can create strong financial incentives for physicians to order unnecessary tests. Thus, the absence of direct billing requirements can result in an increased number of tests and in higher prices being paid for these tests, by patients and by private health insurers.

In several states, physicians are prohibited from billing for tests that are performed by other providers. In these states, when tests are ordered from independent laboratories, physicians do not have financial incentives to order increased testing. As a result, laboratory service utilization rates can be expected to be lower in states with direct billing requirements than in states without such requirements. Moreover, laboratory test prices may be lower in these states than in states without direct billing requirements because there may be more price competition focused on the patient in direct billing states than in non-direct billing states. In non-direct billing states, much of the competition among laboratories is focused on obtaining physician business.

There is an extensive body of research to support the conclusions that physicians: 1) are aware of financial incentives affecting their practices, and 2) respond to financial incentives in their practice and billing behavior. These studies, which have examined utilization and cost experience for laboratory, radiology and other diagnostic services, have produced findings of additional medical care costs from 40 percent to over 500 percent attributable to financial incentives to perform or order more tests.² Within the past year, several studies have been published which focus on the cost impact of physician self-referral practices.³ While these and earlier studies did not focus explicitly on the cost impact of physician mark-up of laboratory tests, their findings suggest that the strong financial incentives related to the opportunity of physicians to mark-up prices of tests performed by others can be expected to result in increased utilization, higher charge levels and higher claims cost.

Study Research Issues

The following specific research issues are addressed in this study:

1. Are laboratory test prices (charges per test) higher in states with no direct-billing requirements (non-direct billing) than in direct billing requirement (direct billing) states?
2. Do laboratory test prices increase more rapidly in non-direct billing states than in direct billing states?
3. Are laboratory utilization rates higher in non-direct billing states than in direct billing states?
4. Are laboratory claims costs higher in non-direct billing states than in direct billing states?
5. What is the estimated national cost impact and potential cost savings (if any) of a change to direct billing requirements for laboratory tests for private pay patients in all states?

OVERVIEW OF STUDY METHODOLOGY AND DATA SOURCES

The methodological approach used includes a comparison of health insurance claims experience in non-direct billing and direct billing states. Ideally, only private payer experience would be analyzed, as the research issues relate explicitly to laboratory services provided under self pay and private insurance programs. However, only limited private claims experience is available for both non-direct billing and direct billing states which can be used to address the research issues identified above. Two data sets are used in this study.

- Medicare Part B Medicare (BMAD) claims data
- Blue Cross and Blue Shield private program claims data.

The two data sets and methodology used with each are described briefly below.

Medicare Data

The BMAD data used reflect claims experience by Medicare carrier area for a sample of laboratory test procedures for 1988 and 1990. Not included in the data set are hospital inpatient and hospital outpatient claims, which are processed under the Medicare Part A program.

The BMAD data set has the advantages of reflecting national experience for a standard benefit program with demographically similar enrollees in all Medicare carrier localities. Moreover, unlike most other health insurance data sets, reliable data are available on enrollment which allows analysis of utilization and claims cost on a per enrollee basis.

The BMAD data does have one significant disadvantage from the perspective of the research issues being addressed in this study. Because providers are not permitted to bill under Medicare for tests they did not directly perform, regardless of the existence or absence of state direct billing requirements for laboratory tests, one may not observe higher Medicare utilization experience in non-direct billing than in direct billing states, even if utilization rates are higher for the non-Medicare population in non-direct billing states. This deficiency does not affect the analysis of laboratory prices, as submitted charges for specific tests would be expected to be the same for self-pay and privately insured persons as for those covered under Medicare.

Described below are the primary components of the study methodology used in the analysis of Medicare claims experience.

Select sample of laboratory procedures for analysis. A sample of laboratory procedures was selected from a larger list of frequently performed tests under Medicare. The sampled procedures, shown in Exhibit 1, include both those commonly performed in physicians' offices as well as those commonly performed by independent laboratories.

Obtain Medicare claims data. BMAD claims data for 1988 and 1990 were obtained from HCFA for the laboratory procedure codes in the study sample for each of the 56 Medicare carrier areas. The BMAD data includes number of services, submitted charges and allowed charges, by provider type. Medicare Part B enrollment by carrier area was also obtained from HCFA.

Identify states in two direct billing requirement categories: direct billing requirement states, and no direct billing requirement states. There are two states, New York and Rhode Island, which prohibit providers from billing for tests they did not directly perform. New York and Rhode Island are designated as direct billing states. In three other states, Connecticut, Michigan and Pennsylvania, a Blue Shield plan with 50 percent or more of the private health insurance market does not pay for laboratory tests which are billed by a provider that does not directly perform the test. Because of their large market shares, the provider payment practices used by these Blue Shield plans can be expected to exert substantial influence on provider practice and billing behavior. Connecticut, Michigan and Pennsylvania have been designated as direct billing states in the analysis. All other states, in which physicians are not restricted from billing for tests they did not perform directly, are designated as non-direct billing states.

EXHIBIT 1

STUDY SAMPLE OF LABORATORY PROCEDURES*

80012 - Automated multichannel test, 12 chemistry tests
81000 - Urinalysis
82150 - Amylase, serum
82270 - Blood; occult, feces, screening
82550 - Creatine phosphokinase (CPK)
82565 - Creatinine; blood
82643 - Digoxin, RIA
82746 - RIA
82947 - Glucose
84478 - Triglycerides
85031 - Blood count, complete CBC
85650 - Sedimentation rate (ESR)
87205 - Smear, with interpretation
88150 - Cytopathology (PAP Smear)

*80019 - Automated multichannel test, 19 or more chemistry tests, was also included in the procedure sample. However, claims data for this code were inadvertently not included in the HCFA data set provided to CHPS.

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Analyze Medicare charge and claims experience. Medicare charge and claims data are combined within each of the two billing restriction categories of states. This is done for each of the 14 laboratory procedure codes in the study sample and for the total of all procedure codes combined. Comparisons are then made between the two categories of states, of charges per test, number of tests per 1,000 enrollees, number of tests per 1,000 office visits and total charges per 1,000 enrollees.

Blue Cross and Blue Shield Data

The second data source used is Blue Cross and Blue Shield claims data which CHPS has access to as a result of an ongoing Multiplan Study of physician costs. Eleven Blue Cross and Blue Shield plans contracted with CHPS in 1991 to conduct a comparative analysis of their charge, claims cost and utilization experience. Claims data were collected and analyzed for a sample of approximately 130 frequently used procedure codes. Among the Blue Cross and Blue Shield (BCBS) plans which participated in the study are Blue Cross and Blue Shield of Rhode Island and Pennsylvania Blue Shield. As noted above, Rhode Island is a direct billing state and Pennsylvania Blue Shield does not pay a physician for a laboratory test unless the physician has actually performed the test. Rhode Island and Pennsylvania are designated as direct billing states in the analysis. The remaining BCBS plans are located in non-direct billing states and allow payment to physicians for laboratory tests if the tests are performed by independent laboratories. The complete list of study plans is provided below:

Direct billing Environments

- Blue Cross and Blue Shield of Rhode Island
- Blue Shield of Pennsylvania

Non-direct billing Environments

- Blue Shield of California
- Blue Cross and Blue Shield of Indiana
- Blue Cross and Blue Shield of Iowa
- Blue Cross and Blue Shield of Kansas
- Blue Cross and Blue Shield of Kansas City
- Blue Cross and Blue Shield of Massachusetts
- Blue Cross and Blue Shield of New Hampshire
- Blue Cross and Blue Shield of Oklahoma
- Blue Cross and Blue Shield of Texas

Included among the study sample procedures are seven frequently performed laboratory procedures. The seven laboratory procedures are:

- 80019 - Automated chemistry tests, 19 or more tests
- 81000 - Urinalysis
- 82947 - Glucose
- 85031 - Blood count (complete CBC)
- 87060 - throat or nose culture
- 88150 - Cytopathology (PAP smear)
- 88304 - Surgical pathology, level III

The BCBS claims data for the eleven study plans enables us to compare submitted charges per test, number of tests per enrollee (covered person) and submitted charges per

enrollee in 1990 between BCBS plans in direct billing environments and BCBS plans in non-direct billing environments.

The Medicare data is used primarily as a source of information on relative charge patterns between non-direct billing and direct billing states. While information is contained in the BMAD data set on utilization and total charges per Medicare enrollee, a direct billing requirement exists under Medicare in all fifty states. Differences which may be found in utilization and total charges between non-direct billing and direct billing states may reflect a spillover effect of financial incentives which exist for private pay patients, i.e., the financial incentive that exists for non-Medicare patients "spills-over" and affects physician behavior for Medicare patients. The Blue Cross and Blue Shield claims experience is used as the primary source of information on relative utilization and total cost experience between non-direct billing and direct billing states.

STUDY FINDINGS

The results of the comparative analysis of Medicare claims experience are summarized in Exhibit 2. Laboratory prices (laboratory charges per test) are 8.9 percent greater in non-direct billing states than in direct billing states. Between 1988 and 1990, charges per test increased more rapidly in non-direct billing than in direct billing states, 11.9 percent compared to 8.4 percent. These total charge per test comparisons include the effects of relatively small differences in distribution of tests between direct billing and non-direct billing states, i.e., there is a slightly more intensive mix of laboratory tests in direct billing than in non-direct billing states. For the same distribution of tests, total charges per test are 8.4 percent greater in non-direct billing states than in direct billing states.

EXHIBIT 2

**COMPARISON OF MEDICARE LABORATORY CHARGE,
UTILIZATION AND COST EXPERIENCE, DIRECT BILLING (DB) STATES
AND NON-DIRECT BILLING (NDB) STATES**

	DB States (NY, RI, NJ, PA, CT)	NDB States (All Other States)	(NDB-DB)/DB
Lab charges per test*, 1990	\$ 11.96	\$ 13.03	8.9 %
Percent Change, 1988-90	8.43%	11.92%	
Lab charges per test for same distribution of tests**, 1990	\$ 12.02	\$ 13.03	8.4
Lab tests per enrollee, 1990	1.23	\$ 1.31	6.5
Percent Change, 1988-90	6.28%	5.03%	
Lab tests per 1000 Office visits, 1990	277	322	16.2
Percent Change, 1988-90	-14.42%	-3.97%	
Lab charges per enrollee, 1990	\$ 14.72	\$ 17.02	15.6
Percent Change, 1988-90	15.24%	17.55%	

*Includes effects of differences in test distributions between NDB and DB states.

**Assumes same distribution of tests in DB as in NDB states.

Also shown in Exhibit 2 are differences between non-direct billing and direct billing states in utilization of laboratory tests per Medicare enrollee and per 1,000 medical office visits. Number of laboratory tests per enrollee and per 1,000 office visits are, respectively, 6.5 percent and 16.2 percent greater in non-direct billing states than in direct billing states. The higher differential between non-direct billing and direct billing states in laboratory tests per 1,000 medical office visits than in tests per enrollee implies a greater number of medical office visits per enrollee in direct billing than in non-direct billing states. The higher rate of visits in direct billing states is likely related to greater relative physician supply in these states. The number of non-Federal physicians per 100,000 civilian population in 1990 is 284.7 in the combined group of direct billing states.⁴ This figure is 25.4 percent greater than the number in non-direct billing states (227.1). The finding of 16.2 percent more laboratory tests per 1,000 visits in non-direct billing states than in direct billing states clearly demonstrate that the higher volume of laboratory tests per enrollee in non-direct billing states than in direct billing states is not caused by a possible higher number of patient visits (or proportionately more physicians) in non-direct billing states. Rather, the observed higher laboratory utilization per enrollee in non-direct billing states occurs despite visits per enrollee being lower in non-direct billing than in direct billing states. Given the higher physician population ratio and associated greater number of visits per enrollee in direct billing than in non-direct billing states, we would expect laboratory tests per enrollee to be greater in direct billing states as well. That the reverse is true adds further credence to the view that it is the lack of direct billing requirements that causes higher laboratory utilization rates in non-direct billing than in direct billing states.

As indicated earlier, the higher laboratory test utilization rates in non-direct billing than in direct billing states likely do not fully reflect differences that would be observed for private pay patients, because laboratory tests in all states are subject to direct billing requirements under Medicare. Rather the laboratory utilization rate differential may reflect only the spillover effect from financial incentives that exist for private patients which can affect physician practice behavior for Medicare patients as well.

The last row in Exhibit 2 provides data on total laboratory charges per enrollee for the 14 laboratory procedures in the Medicare study sample. These figures combine the effects of submitted charges per test and number of tests per Medicare enrollee. Total charges per enrollee are generally in excess of amounts actually paid on average for laboratory tests, because maximum fee levels are often less than amounts charged by providers. However, previous research indicates that differences in total charges for laboratory tests between localities are good proxies for differences in amounts actually paid by private payers for laboratory tests between those localities.⁵ Thus, the existence of high or low laboratory charge levels in a specific locality is generally a good indicator of whether actual fees received by laboratories from private payers are, respectively, relatively high or low in that locality.

Total laboratory test charges per enrollee is \$17.02 in non-direct billing states, or 15.6 percent higher than in direct billing states. It is important to also note from the figures shown in Exhibit 2 that over the 1988-1990 period, percentage changes in laboratory charges per test, laboratory tests per 1,000 medical office visits and laboratory charges per enrollee are each higher in non-direct billing states than in direct billing states. Thus, there is

evidence that cost differences between non-direct billing and direct billing states are increasing over time.

As discussed above, the Blue Cross & Blue Shield data are better suited to developing estimates of the impact of direct billing requirements on utilization of laboratory tests than the Medicare data, because the financial incentives affecting physician laboratory test ordering patterns apply to private insurance covered services and not to Medicare covered services. Findings from the Blue Cross & Blue Shield laboratory claims analysis are summarized in Exhibit 3. Laboratory charges per test are 9.6 percent higher in non-direct billing states than in direct billing states. This figure is approximately one percent higher than the 8.4 percent charge per test differential computed based on the Medicare data. Laboratory charges are higher in non-direct billing states than in direct billing states, even though the cost of living is lower on average in the non-direct billing states than in the direct billing states.

Total tests per enrollee are 36.9 percent greater in non-direct billing states than in direct billing states. However, after adjusting for differences in distributions of tests between direct billing states and non-direct billing states, the difference in number of tests per enrollee between non-direct billing and direct billing states is reduced to 28.3 percent. This figure compares to an estimate of 6.5 percent differential under Medicare, which is interpreted as a spillover effect from financial incentives affecting physician laboratory test ordering patterns for private pay patients. The last row in Exhibit 3 shows the differential between laboratory charges per enrollee in non-direct billing and direct billing states.

EXHIBIT 3

**COMPARISON OF BLUE CROSS AND BLUE SHIELD CHARGE,
UTILIZATION AND COST EXPERIENCE, IN DIRECT BILLING (DB) AND
NON-DIRECT BILLING (NDB) STATES**

	DB States	NDB States	(NDB-DB)/DB
Lab charges per test, 1990*	\$ 19.05	\$ 20.88	9.6 %
Lab tests per enrollee, 1990	.300	.411	36.9
Lab tests per enrollee adjusted for intensity, 1990**	.320	.411	28.3
Lab charges per enrollee, 1990	6.33	8.90	40.6

*Computed using same distribution of tests in DB as in NDB states.

**Differences between NDB and DB states in adjusted lab tests per enrollee (28.3%) are computed by netting out effect of difference in average charges per test between NDBR and DBR states (9.6%) from difference in lab charges per enrollee (40.6%).

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Laboratory charges per enrollee are 41 percent greater in non-direct billing than in direct billing states.

NATIONAL COST IMPACT OF DIRECT BILLING REQUIREMENTS

The final research objective of this study is to estimate the National cost impact in 1992 dollars of a change to direct billing requirement in all states. The underlying assumption of the estimation approach used is that cost and utilization experience in non-direct billing states would be the same as in direct billing states if direct billing requirements were to be imposed at the national level. The estimation methodology used is outlined below:

Step 1. Estimate existing laboratory expenditures. An estimate is developed of private payor (health insurer and consumer pay) laboratory expenditures for laboratory tests performed outside of the hospital setting. It is assumed that government laboratory costs and costs of tests performed for hospital patients would not be affected by change from non-direct billing to direct billing status for tests performed for private pay patients outside of the hospital setting. The estimation methodology requires the following steps:

- Obtain HCFA estimate of private insurance and direct consumer expenditures for physician and other professional services for 1992: \$135.2 billion⁶.
- Estimate laboratory expenditures as a proportion of total Blue Cross and Blue Shield expenditures for physician and other professional

services. The ratio of Blue Cross and Blue Shield plan laboratory charges to total physician charges is 9.3 percent.

- Multiply \$135.2 billion by 9.3 percent -- \$12.57 billion. This figure is towards the low end of the range of estimates of expenditures for laboratory services outside of the hospital setting⁷.

Step 2. Determine the resident populations in direct billing and non-direct billing states.

The 1991 resident population of direct billing and non-direct billing states is computed from data contained in the 1991 Statistical Abstract⁸.

- direct billing states (NY, RI, MI, PA, CT) -- 43,457,000
- non-direct billing states (all other states) -- 205,253 million

Step 3. Compute per capita laboratory costs in direct billing and non-direct billing states.

Using basic algebra, we compute the average cost per capita in direct billing and non-direct billing states based on the following findings from the analysis of Blue Cross and Blue Shield claims experience: total laboratory charges per covered person are 40.6 percent greater in non-direct billing states than in direct billing states⁹.

Average per capita private pay laboratory costs for tests performed outside of the hospital setting are estimated to be:

non-direct billing states -- \$53.22
direct billing states -- \$37.86

Difference -- \$15.36 (41 percent).

Step 4. Compute estimates of national cost impact of adopting national direct billing requirements. The final step in the estimation process is to multiply the non-direct billing-direct billing per capita cost differential by the population in non-direct billing states. The resultant estimates of cost savings which could result from a national change to direct billing is: $205,253,000 \times \$15.36 = \3.15 billion.

This estimate is appropriate if there are no price controls or national fee schedule, for laboratory tests, which could substantially reduce or possibly eliminate price differences among laboratories. However, if some form of price controls or a national fee schedule is adopted, the estimate of potential cost savings resulting from imposition of direct billing requirements may be too high, because it incorporates the effects of both laboratory test utilization and price differences between non-direct billing and direct billing states. A more conservative estimation approach, which is based only on estimated differences in utilization between non-direct billing and direct billing states (28.26 percent), results in a projected savings from adoption of direct billing requirements at the national level of \$2.377 billion¹⁰.

CONCLUSION

The analysis of Medicare and private insurance claims experience yield similar findings regarding the impact of direct billing requirements for laboratory tests on charge and utilization patterns:

- Laboratory charges per test are higher in non-direct billing states than in direct billing states: 8.4 – 9.6 percent higher.

- Laboratory utilization rates are higher in non-direct billing states than in direct billing states: 6.5 percent higher under Medicare and 28.3 percent higher under private insurance.
- Laboratory charges per enrollee are substantially higher in non-direct billing than in direct billing states: 15.6 percent higher under Medicare and 40.6 percent higher under private insurance.

In addition, analysis of Medicare trend data indicate more rapid growth between 1988 and 1990 in non-direct billing than in direct billing states for all of these variables. It is also of interest in interpreting the study findings that the direct billing states, New York, Rhode Island, Michigan, Pennsylvania and Connecticut, are characterized by, on average, higher costs of living and higher physician-population ratios than the non-direct billing states. Because of these factors, we would expect, in the absence of any effects of direct billing requirements, laboratory charge levels and utilization rates to be higher in direct billing states than in non-direct billing states. Study findings which indicate the reverse to be true provide substantial support for the view that it is the direct billing requirement that is the cause of higher charge and utilization experience in non-direct billing states, rather than other factors.

The national cost impact of lack of direct billing requirements for laboratory tests and potential savings which could result from adoption of direct billing requirements in all states is estimated to be in the range of \$2.4 - \$3.2 billion. We believe that these estimates are reasonable, but rough approximations of expected cost savings. Under direct billing requirements, we can reasonably expect reduced incentives to perform unnecessary tests.

This should result in a reduced volume of tests. We can also expect more competitive pricing for tests as the locus of price competition among independent laboratories changes from that of the wholesale market -- physicians' monthly billing account business, to that of the final product market -- consumers and health insurers, who pay for medical care services on their behalf.

FOOTNOTES

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5. Dyckman, Z. Multiplan Study of Physician Claims Experience, Center for Health Policy Studies, January, 1993, Chapter 3.
6. Sonnenfeld, S.T., Waldo, D.R., Lemieux, J.A. and McKusick, D.R. "Projections of National Health Expenditures through the Year 2000," Health Care Financing Review, Volume 13, No. 1 (1991), 1-29.

7. For example, one industry publication suggested that independent laboratory revenues were about \$9.9 billion and physician office laboratory revenues were about \$5.0 billion, for a total of \$14.9 billion. See "Washington Insider's Focus," National Intelligence Report, January 30, 1992. However, there are widely varying estimates for the size of the market. Id.

8. U.S. Bureau of the Census. Statistical Abstract of the United States - 1991, (111th Edition), 1991. Ideally, the population figures that should be used are total population, less those covered under Medicare, Medicaid, CHAMPUS and other government health benefit programs. However, the ratio of population in non-direct billing to direct billing states does not differ markedly if total population is used instead.

9. Solve for X = Per capita laboratory expenditures in direct billing states.

$$205,253,000 \times 1.4057X + 43,457,000X = \$12.57 \text{ billion}$$

$$331,981,000X = \$12.57 \text{ billion}$$

$$X = \$37.86$$

$$1.4057X = \$53.22$$

$$\begin{array}{l} \text{Per capita difference between} \\ \text{non-direct billing and direct billing states} \end{array} = \$15.36$$

10. Solve for X = Per capita laboratory expenditures in direct billing states.

$$205,253,000 \times 1.2826X + 43,457,000X = \$12.57 \text{ billion}$$

$$306,715,000X = \$12.57 \text{ billion}$$

$$X = \$40.98$$

$$1.2826X = \$52.56$$

$$\begin{array}{l} \text{Per capita difference between} \\ \text{non-direct billing and} \\ \text{direct billing states} \end{array} = \$11.58$$

Chairman STARK. Let me just make sure that I understand what we are all talking about here.

Your clients, I presume, are all under the original 88 restriction as diagnostic labs. So a physician cannot have an ownership interest in it if, in fact, they refer a Medicare patient to it. You are already under the umbrella relative to Medicare. Your labs or all diagnostic labs must bill Medicare directly; right?

Ms. FOSTER. That is right.

Chairman STARK. So you are under the hammer for all Medicare, and Medicaid, I presume. You suggest that you would have no objection or would support—I think you said this in your previous incarnation an hour ago—that you would support including all patients, private and government, under the prohibition that physicians not have an ownership interest.

Ms. FOSTER. Absolutely.

Chairman STARK. In addition, what you are saying, is that it is often the practice of labs to bill the doctor and then the doctor tacks on a markup or an added fee to the patient and/or the private insurance company, and that as long as we intend to make the ownership interest apply to all physician bills, whether it is private or government, we should extend this same prohibition on markups or indirect billing, whatever you want to call it, across the board. That indirect billing really is just another form of kickback to the physician.

Am I catching on?

Ms. FOSTER. I am not sure I would characterize these as kickbacks, maybe financial incentives.

Chairman STARK. It is like tips.

I am also hearing, although this may not be the universal feeling, that we could buy off your group to the 76 level if we did in fact go to the direct billing.

Ms. FOSTER. That is true for ACLA.

Chairman STARK. I am not sure that is universal. I am not sure Mr. Salton's group takes that position?

Mr. SALTON. No, we do not take that position.

Chairman STARK. I understand. That was not my idea.

You indicated, Hope, I don't know what Mr. Salton suggested, that you would as soon go with a freeze on the update as the reduction to 76, although I suspect that saves you a lot of money.

Ms. FOSTER. Correct.

Please don't understand, we will—

Chairman STARK. No, I would just have to suggest that if, in fact, that is what the committee does to meet our reconciliation target, that it would be done more out of a time constraint, and as you correctly anticipate, forgoing the anguish of having to go through this thing twice.

There are some things in the administration proposal which I endorse. I think they are great.

There are others I think might not work well at all. I am sure that all my colleagues have a variety of interest in those, and I have a hunch we would be here a long time as we have been in past years on reconciliation, if we try to do it line item by line item.

Understanding that at very latest, we would be back here the first part of next year, probably reviewing a whole host of changes

in the way we reimburse your clients out of health care reform, which might be as onerous as any of these in there for you.

I would not want to not play straight with you. You suggested that you might be pleased to just see a postponement of the update. That is very tentative. That is almost a placeholder.

It would not ensure that actually we would not come back to those issues if we were to complete the major reform before the end of the year. We might say, wait a minute, and it might all get folded back in to reconciliation. That leaves the issue of uncertainty.

But I would not want you all, who have been most cooperative and helpful to the committee, to think that this idea of a possible postponement of the update is anymore than for the convenience of the committee so that we are able to get right on to addressing what might be more complex and that is the overall health care reform.

I appreciate your testimony. I am glad I understand your position.

I concur in the direct billing. I don't know that there is any technical problem. It is in H.R. 200.

Ms. FOSTER. Yes, it is.

Chairman STARK. Have you seen the language there?

Ms. FOSTER. Yes. We were hoping because of the jurisdictional issues, that we could get a placeholder on reconciliation and deal with health care reform, at which time direct billing would be an appropriate topic for debate, and then go back to the Medicare cuts.

Chairman STARK. I would not mind throwing direct billing into reconciliation. It would save some money.

I am not such a purist there. Anything that saves money would be good or we could get it in H.R. 21.

We need to pay for a few things in H.R. 21, the leftovers from H.R. 11. It might fit in there a little better.

Ms. FOSTER. I hope the study that is appended to our testimony will help you demonstrate the savings that direct billing will provide because they are quite substantial.

Chairman STARK. What happened to Nevada again? How did they hold that so flat on that chart?

Mr. SALTON. They held that flat by prohibiting physicians from billing for Medicaid. What they did is starting in 1984 and 1983, they stayed flat by going to direct billing. Starting in 1983 or 1984, they stayed flat by requiring direct billing.

Chairman STARK. When did direct billing become the law?

Mr. SALTON. This is just Medicaid.

In 1982, they increased the fees to the laboratories that were doing the work and they were able to maintain that basically zero growth in expenditures.

When you take the physician out of the loop, monies are saved. It is pure and simple.

Mr. KLECZKA. The speaker also addressed my State, which ended up on the top of this chart, which is not very flattering.

What happened in Wisconsin?

Mr. SALTON. Those are the numbers our research turned up, sir.

Mr. KLECZKA. OK.

But you don't know specifically what happened to Wisconsin and Colorado, why it went so wacko there?

My State and Colorado are aberrations,, to say the least. You have no specifics as to why?

Mr. SALTON. No, sir.

Mr. KLECZKA. Is it possible to ascertain those?

Mr. SALTON. We will find out what the reasons are, what we assume the reasons are and get back to you.

Mr. KLECZKA. In Wisconsin, Medicaid is driving the budget. Maybe you could help the Governor out by looking at this particular project.

Mr. SALTON. There is per recipient. It was in a very startling study that we found this out.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Are there any other States that went to direct billing and did not have Nevada's experience?

Mr. SALTON. Yes, there is one, but there are other problems they encountered, the State of New York. They have had a lot of fraud, abuse and whatnot. That kind of skewed the whole result of the Medicaid study.

Mrs. JOHNSON. Were there any other changes that Nevada made at the same time they adopted direct billing?

Mr. SALTON. There were only two laboratories doing the laboratory work and that would be Las Vegas and Reno. Some of the critics pointed to it and said that would be considered competitive bidding. But it was not, because the State of Nevada set the fees and they awarded it to those two States only because there are not that many laboratories in the State of Nevada.

Mrs. JOHNSON. So were the savings the result of the State setting the fees or was it the result of direct billing?

It appears from what you just said that it would have been more a consequence of the States setting the fees rather than direct billing.

Mr. SALTON. No, they increased the fees.

Mrs. JOHNSON. But then they set those fees and kept them there.

Mr. SALTON. That is true, but they notice that the utilization has decreased with direct billing.

Ms. FOSTER. One of the things that happened in Nevada, and I don't have the information that the American Association of Bioanalysts has on this, but I have reviewed the documents on Nevada. At the time they determined they would only pay these two laboratories for Medicaid tests, they also stopped paying physicians for office laboratories. So we had both the issue of markup and the tests in the physician office settings.

Mrs. JOHNSON. Part of the constraint on volume could have affected the quality of care. When you have an urinary track infection, you need an immediate lab test. If the physician cannot do a urinalysis, I can tell you, it is painful.

So, without more data than this, I would certainly not want this committee—because if it were that simple, well, in my State, it is like my colleague's State, it is hurting over Medicaid increases in costs. I don't think it is quite so simple.

You point out they cut out physician tests because physician tests have a lot to do with responsiveness of care and whether it is qualities of care or not. This is something we ran into earlier.

Chairman STARK. They just didn't pay for them?

Ms. FOSTER. They would pay for tests performed in the two different laboratories, that was it. These agreements, I understand, were negotiated.

Mrs. JOHNSON. You would really have to see what happened to those kinds of tests that were really crucial to an immediate diagnosis and whether or not the Medicaid patients suffered reduced access to those tests. It is absolutely true that as Medicaid reimbursements to physicians flattens out, Medicaid recipients suffered a lack of access to physicians. So one would assume that they probably suffered an a lack of access to test that would affect the quality care. Experience would lead to that conclusion. I certainly would not want to assume without further data.

Ms. FOSTER. I really don't know. I know something about how the procurement methodology was developed.

Mrs. JOHNSON. Your comments have been very helpful. It tells us that there was something unique in Nevada. They chose two laboratories. In other States, that may be a problem. In New York, that has to be looked into.

Thank you.

Chairman STARK. Thank you very much.

Our next panel will consist of James Liken, the president of the Liken Medicare Center on behalf of the National Association of Medical Equipment Suppliers; John Yarbrough, president of the American Orthopedic & Prosthetic Association; Alan Parver, National Alliance for Infusion Therapy; and Irene Paige, Home Care Coalition.

I thank you for your patience. I welcome some of you back and others to the committee for the first time.

I would ask if you would summarize or expand on your written testimony which will appear in the record in its entirety.

Jim, do you want to lead off?

STATEMENT OF JAMES W. LIKEN, PRESIDENT, LIKEN MEDICARE CENTER, PITTSBURGH, PA., ON BEHALF OF THE NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS, ACCOMPANIED BY CORRINE PROPAS PARVER, PRESIDENT, NAMES

Mr. LIKEN. Thank you.

Mr. Chairman and committee members, my name is James Liken, I am the president and owner of Liken Medicare Center, a home medical equipment (HME) company that has four locations, serving western Pennsylvania, West Virginia, and eastern Ohio.

I am a board member of NAMES, the National Association of Medical Equipment Suppliers, and I have with me Corrine Parver who is the president of NAMES.

Just as an aside, NAMES, as an association, and I personally support what you are doing on the ban on physician self-referral. We are with you on that one.

I am here today to express my personal belief that certain provisions of the administration's fiscal year 1994 budget would erect further barriers to using home care at the very time when public policy should be encouraging HME and other home care services as a less costly, patient-preferred and clinically effective alternative to institutional care.

NAMES members support the overall intent of President Clinton's call to all Americans to help curtail escalating health care costs and help reduce the staggering Federal deficit. We recognize the paramount necessity of reducing unnecessary or excessive Medicare program costs to help bring Federal spending for health care in check. In fact, the HME services industry has taken the initiative to work with policymakers to develop responsible solutions to problems within its own industry. This was clearly evident during the 102d Congress, with NAMES effort to help develop a comprehensive HME ethics bill, H.R. 2534, which helped "pave the way" for the myriad of other such bills with similar intent. Many provisions of H.R. 2534, included in legislation vetoed by President Bush, H.R. 11, have since been reintroduced, H.R. 21 and 22, and are pending before this committee.

The HME services industry, a valuable element in our Nation's health care system, helps make homecomings possible for many sick and elderly Americans. The tremendous range of products and services provided by HME suppliers range from so-called "standard" HME items such as hospital beds and walkers, to highly-sophisticated services such as oxygen ventilators and concentrators; parenteral and enteral nutrition; antibiotic, chemotherapy and other drug therapies administered intravenously; and specialized rehabilitation equipment customized for the unique needs of persons with disabilities and fitted by rehab technology suppliers.

NAMES members are willing to do their part to assist the administration and Congress in reducing Medicare expenditures, but the budget cannot be balanced on the backs of this industry through repetitive consideration of ill-thought out proposals that have been rejected time and time again.

The fiscal year 1994 deficit reduction initiatives in President Clinton's Economic Plan include proposed savings from the HME services industry of more than \$680 million over the next 5 years. This proposal is a frightening addition to reimbursement reductions totaling \$80 million in 1990 and \$215 million in 1991.

This disproportionate level of cuts, totaling more than \$800 million, are targeted at an industry that accounts for only \$1.8-\$2.0 billion in annual Medicare expenditures, barely 2 percent of the entire Medicare budget.

Of most concern to HME suppliers are provisions which would: adjust HME fee schedules downward with an upper limit based upon the median, instead of the current methodology using the weighted median; grant the Department of Health and Human Services, (HHS) unfettered authority to adjust HME rates based on totally undefined "market factors"; grant HHS the authority to re-classify certain items of HME; and clarify HHS authority to use "inherent reasonableness" to adjust payment amounts for HME.

Specifically, the HME services industry is deeply concerned with the administration's proposal to set payment rates for HME items at the national median. In OBRA 1987, Congress ended the method of payment for HME based on the reasonable charge methodology, and substituted regional fee schedules in its stead.

In OBRA 1990, Congress curtailed regional pricing in favor of a 3-year, phased-in national fee schedule. Because of the disparities and numerous flaws in the Health Care Financing Administration,

(HCFA) data used to calculate the HME fees originally, Congress rightly viewed that the only equitable mechanism to calculate the new national fees was according to the weighted mean.

We are now in the final year of phasing-in to the national fee. Virtually all major pricing disparities between Medicare payments amounts in various States have now disappeared. To impose yet another change and administrative burden on carriers and HME supplies alike at this time by again revising the national payment rate at the median of prices for HME items would mean going back into the old, flawed HCFA data base—a proposition Congress already rejected and, we believe, should not revisit.

The administration's fiscal year 1994 budget also would grant the Secretary of HHS authority to remove nebulizers and aspirators from the current statutorily specified category of "frequent and substantial servicing" in the Medicare part B DME benefit. When this issue first was considered by Congress last year, NAMES recommendation was and still remains that Congress delay action on this provision until a comprehensive study may be conducted by HHS and the HME services industry to determine the proper payment categories for these items, so as to ensure adherence to ongoing patient health and safety standards.

However, if there are to be any such changes made, Congress should require HCFA to establish adequate coding and coverage policies prior to implementation of any change. Separate reimbursement for disposable supplies and accessories used in conjunction with these items also would have to be statutorily defined.

For those patients with strong family support systems or who otherwise may have sound physical and mental faculties, it may be appropriate in some cases to allow for the purchase of standard nebulizers with compressors. Yet, other patients who are more dependent require regular checks on even those more "standard" items.

Only the physician is in the appropriate position to determine the patient's ability to use nebulizers without routine checkups by a qualified HME supplier. Since patient health and safety is a most critical component, and must remain the focal point of our concerns, statutory changes to this benefit only should occur after careful study and consideration.

NAMES also understands that an additional provision under consideration by Congress as part of the fiscal year 1994 budget contains language to clarify HHS authority to use "inherent reasonableness" adjustments to change payment amounts for all HME items. Any such clarification should require HHS to base "inherent reasonableness" decisions on supplier prices and costs applicable at the time the item is finished, including an HME supplier's total service costs, such as delivery of equipment, Federal regulations compliance requirements and similar related costs.

The HME services industry also would like to note its opposition to policy documents issued by the administration in February 1993, which propose to permit competitive bidding for HME and related services. Congress should be concerned that the HME industry's service component, so integral to ensuring patient health and safety when providing needed home medical equipment, may diminish or disappear if competitive bidding for HME is implemented.

For example, accreditation organizations have documented deficiencies and a poor quality of HME services provided by many winning bidders under the Veterans Administration competitive bidding process. Congress should anticipate even greater problems if competitive bidding were applied under Medicare.

Only a few companies likely would have the capital necessary to expand into new services in order to take on large competitively bid contracts. This could easily lead to concentrations of Medicare's entire HME benefit in the hands of a relatively few suppliers.

In short, all evidence suggests it is virtually impossible to design and administer a competitive bidding process without damaging the market, compromising quality and leading to higher prices in the long run. If a winning bid is awarded solely to one provider, this certainly will drive many small companies out of business; the sole winner in future years thus would have a considerably reduced level of competition.

With policymakers now considering various mechanisms to reform health care delivery by implementing some type of "managed competition," it is illogical to create a new scheme at this time just for HME services that removes the entire concept of competition out of the marketplace altogether.

As described in the administration's February 1993 policy document entitled: "A Vision of Change for America," the President's fiscal year 1994 budget also would empower HHS and HCFA to make payment determinations based solely on undefined "market factors." This would allow HCFA unfettered authority to impose virtually any proposal to reduce funding for HME, including many changes that Congress already has considered and refused to enact in prior years—without the benefit of debate and discussion in a congressional forum.

This proposal, originally advanced by the previous administration, was rejected outright by Congress in the past. Members of Congress quite rightly viewed an absolute delegation of carte blanche authority to HCFA to set Medicare reimbursement for HME at-will in the future as an improper delegation of legislative authority. We urge you again to continue to reject this unwise proposal.

As a supplier who oversees the provision of HME services to countless Medicare beneficiaries on a daily basis, I urge you to remember that the HME services industry already has been singled out among health care providers for an extreme, disproportionate level of reimbursement cuts in the past.

These reductions have had a harsh impact on suppliers' abilities to meet the needs of their patients. In some instances, HME companies either have been forced to close altogether or, at a minimum, to redefine their service capabilities, particularly in rural areas. In such cases, Medicare beneficiaries have been placed in severe jeopardy of losing access to critically important health care services.

One of my current respiratory patients, in fact, was the unintended victim of a decision by a large HME company to cease providing high cost/high service HME in some areas of the country. While it is fortuitous that my company was able to assume providing respiratory services and supplies to this patient to enable him

to continue to stay at home and out of a nursing facility, I know that other Medicare beneficiaries have not been so lucky.

In closing, NAMES recognizes the difficulties faced by Congress and this committee in developing a responsible legislative package that will reduce the Federal deficit and still address America's critical health care needs. At the same time, it is counterproductive to enact legislation which does not work to our common goals of allowing people to be discharged sooner from an institution and permitting people with severe disabilities to lead productive lives. Such obviously cost-effective and compassionate means of providing health care in the home should be encouraged and fostered where possible and clinically appropriate.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY
OF
JAMES W. LIKEN,
PRESIDENT, LIKEN MEDICARE CENTER,
AND
REPRESENTING
THE NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS
ON THE
ADMINISTRATION'S FY 1994 MEDICARE BUDGET
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE
HEARING OF
APRIL 20, 1993

Mr. Chairman and Members of the Committee: I am pleased to testify before you today. My name is James Liken. My company, Liken Medicare Center, currently has four facilities that serve the tri-state area of Western Pennsylvania, West Virginia and Ohio. I have 16 years' experience as a supplier of home medical equipment (HME) services.

I currently serve on the Board of Directors and was a past Chair of the National Association of Medical Equipment Suppliers (NAMES), the national trade association representing the HME services industry exclusively. Thus, I appear before you today not only on behalf of HME suppliers across the country, but also to express my personal belief that certain provisions of the Administration's fiscal year 1994 (FY 94) budget would erect still further barriers to using home care at the very time when public policy should be encouraging HME and other in-home services as a less costly, patient-preferred and clinically effective alternative to institutional care.

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NAMES members are willing to do their part to assist the Administration and Congress in reducing Medicare expenditures, but the budget cannot be balanced on the backs of this industry through repetitive consideration of ill-thought out proposals that have been rejected time and time again.

The FY 94 deficit reduction initiatives in President Clinton's Economic Plan include proposed savings from the HME services industry of more than \$680 million over the next five years. This proposal is a frightening addition to reimbursement reductions totaling \$80 million in 1990 and \$215 million in 1991. This disproportionate level of cuts, totaling more than \$800 million, are targeted at an

industry that accounts for only \$1.8-\$2.0 billion in annual Medicare expenditures, barely 2 percent of the entire Medicare budget!

Of most concern to HME suppliers are provisions which would:

- Adjust HME fee schedules downward with an upper limit based upon the median, instead of the current methodology using the weighted mean;
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- Grant HHS the authority to reclassify certain items of HME; and
- Clarify HHS' authority to use "inherent reasonableness" to adjust payment amounts for HME.

Specifically, the HME services industry is deeply concerned with the Administration's proposal to set payment rates for HME items at the national median. In OBRA 1987, Congress ended the method of payment for HME based on the reasonable charge methodology, and substituted regional fee schedules in its stead. In OBRA 1990, Congress curtailed regional pricing in favor of a three year, phased-in national fee schedule. Because of the disparities and numerous flaws in the Health Care Financing Administration (HCFA) data used to calculate the HME fees originally, Congress rightly viewed that the only equitable mechanism to calculate the new national fees was according to the weighted mean.

We are now in the final year of phasing-in to the national fee. Virtually all major pricing disparities between Medicare payment amounts in various states have now disappeared. To impose yet another change and administrative burden on carriers and HME suppliers alike at this time by again revising the national payment rate at the median of prices for HME items would mean going back into the old, flawed HCFA data base – a proposition Congress already rejected and, we believe, should not revisit.

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contracts. This could easily lead to concentrations of Medicare's entire HME benefit in the hands of a relatively few suppliers.

In short, all evidence suggests it is virtually impossible to design and administer a competitive bidding process without damaging the market, compromising quality and leading to higher prices in the long run. If a winning bid is awarded solely to one provider, this certainly will drive many small companies out of business; the sole winner in future years thus would have a considerably reduced level of competition. With policymakers now considering various mechanisms to reform health care delivery by implementing some type of "managed competition," it is illogical to create a new scheme at this time just for HME services that removes the entire concept of competition out of the marketplace altogether.

As described in the Administration's February 1993 policy document entitled: "A Vision of Change for America," the President's FY 94 budget also would empower HHS and HCFA to make payment determinations based solely on undefined "market factors." This would allow HCFA unfettered authority to impose virtually any proposal to reduce funding for HME, including many changes that Congress already has considered and refused to enact in prior years—without the benefit of debate and discussion in a Congressional forum. This proposal, originally advanced by the previous Administration, was rejected outright by Congress in the past. Members of Congress quite rightly viewed an absolute delegation of carte blanche authority to HCFA to set Medicare reimbursement for HME at-will in the future as an improper delegation of legislative authority. We urge you again to continue to reject this unwise proposal.

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In closing, NAMES recognizes the difficulties faced by Congress and this Committee in developing a responsible legislative package that will reduce the Federal deficit and still address America's critical health care needs. At the same time, it is counterproductive to enact legislation which does not work to our common goals of allowing people to be discharged sooner from an institution and permitting people with severe disabilities to lead productive lives. Such obviously cost-effective and compassionate means of providing health care in the home should be encouraged and fostered where possible and clinically appropriate.

HME suppliers do much more than just deliver home medical equipment to Medicare beneficiaries and others—they work intensively with physicians, discharge planners, nurses, therapists and other health care professionals as necessary to select appropriate equipment; set up the equipment and educate patients and their caregivers on how to use the equipment properly; service the equipment 24 hours a day, every day; undergo rigorous disinfection processes when equipment is retrieved; and complete expensive, ever-increasing Medicare paperwork for their patients. This high level of home care services should be encouraged—not destroyed.

I will be pleased to answer any questions you may have. Thank you for allowing me to testify.

STATEMENT OF JOHN M. YARBROUGH, PRESIDENT, AMERICAN ORTHOTIC & PROSTHETIC ASSOCIATION, AND CHAIRMAN AND CHIEF EXECUTIVE OFFICER, TRAUTMAN'S MINNEAPOLIS ARTIFICIAL LIMB CO. AND ROCHESTER ORTHOPEDIC APPLIANCES, MINNEAPOLIS, MINN., ACCOMPANIED BY DAVID SCHULTZ

Chairman STARK. Mr. Yarbrough.

Mr. YARBROUGH. Thank you, Mr. Chairman.

My name is John Yarbrough. I am the president of the American Orthotic & Prosthetic Association.

I am accompanied by an associate, David Schultz. He is a certified prosthetist/orthotist and a former officer of the association.

I request that the written statement of the American Orthotic & Prosthetic Association, the American State of the Art Prosthetic Association, and the Amputee Coalition of America be placed in the record.

I will make a short presentation for the subcommittee at this time.

We appreciate this opportunity to offer input into your deliberations on the current budget proposal. Just a few words about AOPA.

We are a national membership organization of allied health providers who operate some 1,200 patient care facilities, serving the needs of physically challenged Americans.

What do orthotists and prosthetists do?

They evaluate and assess patient's disabilities; design and fit braces, orthoses, and artificial limbs, prostheses, to enable physically challenged individuals to lead independent and productive lives.

President Clinton has proposed that certain investments be made today in order to save unnecessary and wasteful spending tomorrow. The benefits of that philosophy are clearly demonstrated in the investment for rehabilitation of individuals with physical disabilities.

We believe that it is indisputably obvious that failure to provide appropriate braces or artificial limbs far exceeds the cost of meeting the needs of challenged individuals. The price of failure can include: State and Federal assistance for those who cannot return to gainful employment; personal care for those who can no longer live independently, and increased medical care expenditures for those whose health deteriorates because of forced inactivity.

While we support the philosophy and intent of the administration's budget proposal, we are deeply concerned with a specific recommendation covering orthotics and prosthetics.

The initial proposal included in the DME section stated:

In addition, the fee schedule for prosthetics and orthotics would be tightened by using DME payment rules with the national median as the limit.

Although the April 8 version of the budget does not mention O&P, we believe it continues the past practice of categorizing O&P as durable medical equipment.

This practice has led to confusion and serious misunderstanding with resulting policies and actions that are neither appropriate nor effective.

In order to effectively contain costs while assuring appropriate O&P care we must understand the nature of the services involved.

To do this it is crucial that: One, O&P be recognized by Medicare as distinct and separate from the businesses of vending and renting durable medical equipment; and two, O&P care be provided by orthotists and prosthetists certified by a qualified board.

The basis for these positions is: First, O&P services are very personal services delivered only in response to a physician's prescription. Second, professional services are the major component of the complete O&P patient care. Third, the O&P allied health field has—a defined body of clinical and technical knowledge—a core of certified practitioners with a formalized education structure. Fourth, orthotists and prosthetists, as allied health professionals regularly participate as part of a rehabilitation team with physicians, therapists, and other health care professionals.

And finally, the fabrication, distribution and delivery of custom braces and artificial limbs are very different from durable medical equipment because these devices are not mass produced, warehoused, vended off a retail dealer's shelf, rented or reusable by multiple users, and they are not sold in volume by telemarketing.

We believe these facts clearly demonstrate the regulations and controls for DME are not appropriate for O&P, and are compelling reasons that O&P should be recognized as separate and distinct from DME.

In addition, it would appear to be prudent to separate O&P as a matter of sound management practice.

The practice of lumping O&P with DME has resulted in a lack of reliable information and data needed to make good management decisions. A recent "Home Health Line" reports that HCFA actuaries have reported that spending for "orthotics and prosthetics" increased by 27 percent in 1990 and 30 percent in 1991.

This report contrasts with the fact that Medicare fee updates for artificial limbs and braces were 0 percent in 1990 and only 4.7 percent in 1991. This conflicting information suggests that factors other than artificial limbs and braces fee increases were the major cause of the reported spending increases.

Why this extreme difference?

Because HCFA's definition of O&P includes ostomy, urological and other medical supplies.

Data included in a preliminary report from a GAO study, ordered by this subcommittee, provides some useful insight as to the possible cause of those Medicare increases.

A comparison of spending on 15 high usage procedural codes for the years 1986 reveals an increase of \$33.4 million in 1991.

GAO examined this increase and found that 85 percent, some \$28.5 million was attributable to increased utilization—and only 15 percent—or \$4.9 million—resulted from fee increases.

A chronology of fee update adjustments for braces and artificial limbs from 1983 shows that increases since 1984 have been below an average of 3 percent per year. A figure well below rates of inflation.

We recognize that there is very limited data available for good policy decisions on O&P, despite congressional action that acknowledged the separate status of O&P in OBRA 1990.

The continued practice of categorizing O&P as durable medical equipment has resulted in a very limited data base for policy decisions. This should be rectified.

In conclusion, we strongly suggest: One, that O&P be recognized as separate and distinct from DME, and two, that proper use of O&P services is a very sound investment and appropriate utilization is essential for effective cost containment and is consistent with the objectives of the Americans with Disabilities Act.

Again, I thank the subcommittee for the opportunity to share the views of the organized O&P field with you today and we will answer any questions you may have at this time.

[The prepared statement follows:]

**TESTIMONY OF JOHN M. YARBROUGH
AMERICAN ORTHOTIC AND PROSTHETIC ASSOCIATION**

Good morning. My name is John Yarbrough and I am the President of the American Orthotic and Prosthetic Association (AOPA). I thank the Committee for offering AOPA the opportunity to present its views, which are supported by the American State of the Art Prosthetic Association (ASOTAPA) and the Amputee Coalition of America, on the President's budget proposal and proposals to modify Part B of the Medicare program relating to orthotics (braces) and prosthetics (artificial limbs) (O&P). While we are here today to talk about the President's budget, we recognize that this budget is also a vehicle used to develop and implement public policy.

AOPA is a national membership organization which represents more than 800 allied health care provider firms who provide O&P services to individuals with physical disabilities throughout the United States. Orthotic and prosthetic practitioners employed by AOPA member firms design and fit orthoses (braces) and prostheses (artificial limbs) which enable physically challenged individuals to overcome significant orthopedic conditions and serious injuries and return to active productive lives.

The Administration's Proposals for Fiscal Year 1994

In introducing his budget this year, President Clinton stressed the need to invest today to build a stronger tomorrow, a tomorrow that does not demand enormous amounts of money and sacrifice to right pervasive problems. Instead, investment made today for prevention and preservation will build a strong future, one not built upon a devastatingly weak foundation. We believe these principles hold true for the successful rehabilitation of individuals who sustain muscular, skeletal and limb-loss disabilities. Specifically, early investment in rehabilitation that provides braces and artificial limbs mainstreams people. Mainstreaming entails restoring people to their optimum level of function, allowing them to pursue employment and other activities, and thus lead productive, independent lives. These independent Americans contribute to society.

Failing to restore individuals to their optimum level of function increases dependency, thus limiting their ability to remain productive, economically independent members of society. This failure also increases their need for added medical and social service care, and state and federal assistance programs, which impose great long-term expenses upon society.

To accomplish the goals of reducing health care expenditures tomorrow by providing assistive technology today, such as quality orthoses and prostheses, it is crucial that O&P care is:

1. recognized by Medicare as distinct and separate from the vending and renting of durable medical equipment; and,
2. provided by qualified practitioners certified by the American Board for Certification in Orthotics and Prosthetics.

Separation of O&P from DME and Qualifications of Providers

In the past, confusion has arisen over the definition of orthotics and prosthetics. While in a limited sense the definition of orthotics and prosthetics has been addressed by Congress, the results have been very broad and have included a number of items not characteristic of O&P care. To clarify this confusion, the organized field of O&P is strictly defining orthotics as "braces" and prosthetics as "artificial limbs", and proposes that Congress do the same.

Orthotics and prosthetics are inherently different from durable medical equipment (DME) in that O&P health care "services" are

highly individualized to specific patient needs, and are as much a professional "service" as a "product". The "product" element of the O&P practice is only part of the total package of treatment provided by an O&P practitioner, and reimbursement for the service element is specifically included in O&P's Medicare reimbursement codes. O&P devices are generally custom-fabricated and custom-fit for each individual, unlike DME products, which are rentable and reusable by other individuals.

Approximately 2,700 certified practitioners provide artificial limbs and braces that are designed in response to a physician's prescription and meet the unique needs of the individual with disabilities. O&P patient health care services include the evaluation and assessment of the disability, consultation with an attending physician, design and fabrication of an orthotic or prosthetic device, along with the fitting and orientation to the appropriate care and use of the device.

Further, the O&P profession is completely different from DME in that O&P has a defined body of clinical and technical knowledge, and a core of specially credentialed practitioners, with formalized education provided by well-established post-baccalaureate education programs offered at eight major American universities.

It is important to note that these significant differences between O&P and DME were recognized by Congress in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). In practice, however, the statutory separation has been in name only, as no meaningful separation in the treatment of O&P has occurred with respect to the Health Care Finance Administration's (HCFA's) philosophical and financial practices. The past practice of continuing to inappropriately group O&P with DME, despite the OBRA '90 recognition of separation, has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in the health care delivery system.

The President's 1994 budget proposes to once again treat O&P services the same as DME by inappropriately placing O&P's highly specialized patient services with a group of apparatus providers who primarily sell or rent products to support certain treatment modalities. We believe that this approach is not a step in the right direction and strongly support the separate treatment of O&P from DME for coverage and reimbursement in the Medicare program.

Congressional Proposals Pertaining to O&P and DME

There are several proposals in Congress that address fraud and abuse which are believed to be rampant in the delivery of DME products. The organized field of O&P supports these efforts to eradicate fraud and abuse, but does not believe these proposals are applicable to the O&P field, because, as previously discussed, the delivery of O&P health care services is inherently different from the provision of DME.

Conditions of Coverage

The second area that is crucial for helping to reduce health care expenditures is **conditions of coverage**. To ensure that all Medicare patients enjoy quality O&P care, the organized O&P field supports establishing conditions of coverage. While the Medicare billing system was designed to permit fair and equitable reimbursement of O&P devices and services, these codes are used, not only by O&P professionals, but by apparatus providers who do not provide the same product/service combination as O&P practitioners. This has created significant and unintended problems in Medicare reimbursement of O&P services, and may contribute to DME fraud and abuse. Since O&P practitioners are generally not subject to state licensure, O&P provider numbers and codes may be accessed by virtually anyone.

Although O&P practitioners provide health care products and services for which they are highly trained and certified, the Medicare program has no conditions of coverage for O&P services, as it does for similar services, such as those of physical therapists. Such an omission puts individuals with disabilities at risk through exposure to unqualified practitioners. To address this, the organized field of O&P recommends that conditions for coverage be established under Medicare for the provision of O&P products and services. This measure would serve to promote the quality control of O&P health services provided to Medicare beneficiaries. A definitional standard similar to the one used by HCFA for physical therapists could easily be incorporated into HCFA administrative policies. This measure could be accomplished in the context of the budget proposal.

Such conditions for coverage also compliment President Clinton's goal of investing today, in this case investing in the recognition of quality care, to ensure less expenditure tomorrow. Further, the creation of conditions of coverage for O&P services under Medicare would greatly benefit the Medicare beneficiary as well as HCFA, thereby establishing high standards for quality care.

Conclusion

It is my hope that this testimony has demonstrated that the organized field of O&P has acted responsibly with respect to the delivery of health care in the past and has not significantly contributed to spiralling health care costs, and more specifically, has not contributed to inflation that results from DME fraud and abuse. For example, it is important to note that the O&P field: CAN NOT AND DOES NOT market artificial limbs and braces through unsolicited telephone calls; CAN NOT AND DOES NOT sell artificial limbs and braces to individuals who do not need them; CAN NOT AND DOES NOT engage in carrier shopping; and, CAN NOT AND DOES NOT provide unnecessary tests to bilk Medicare. Therefore, using generic methods of curbing fraud and abuse in DME inadvertently makes it impossible for responsible O&P practitioners to provide devices that are functionally appropriate rather than just medically necessary. Once again, functional necessity is a cost-effective investment made today to assure an independent and productive future for the physically challenged.

Attempts to reduce or restrict reimbursement for O&P services would significantly impact the profession adversely. To illustrate, increases in reimbursement for O&P practitioners over the last ten years have totalled no more than twelve percent (12%), at times as low as zero, and never more than five percent annually. These limited increases in Medicare reimbursement have been difficult to sustain since O&P practitioners have no control over the costs of their components. Should a component increase in cost by 15 percent from manufacturers, the O&P provider can not pass the increase to medicare or the patient, but must cover this increase within the allowed reimbursement amount for the finished O&P device and service.

Finally, because the population that uses O&P devices and services is so limited when compared to the entire health care delivery system, it is impossible to recapture production and research costs through economies of scale, as other products in the marketplace often do. In this regard, O&P has problems similar to the orphan drug industry.

Quality O&P services, which are investments in rehabilitation/preventive care that save money on expensive treatments in the future, are a natural precursor to the goals embodied in the American with Disabilities Act (ADA). Enabling people with disabilities to reenter the mainstream of American society through assistive technology and devices is the vehicle upon which the spirit of the ADA will be fulfilled. In order for O&P practitioners to continue providing quality care to amputees and others with disabilities, the O&P field must be recognized for the customized and individualized services they provide and be treated distinct and separate from durable medical equipment.

Once again, I thank you for this opportunity to share the views of the organized field of O&P with you today and am pleased to answer any questions you may have at this time.

Chairman STARK. Thank you, Mr. Yarbrough.

We have two votes that will come back to back. I will recess for approximately 15 minute.

I hope by the end of the half hour we can resume the hearing.
[Recess.]

STATEMENT OF ALAN K. PARVER, PRESIDENT, NATIONAL ALLIANCE FOR INFUSION THERAPY

Chairman STARK. Mr. Parver, please proceed.

Mr. PARVER. Good afternoon, Mr. Chairman, and members of the subcommittee. My name is Alan Parver, and I am the president of the National Alliance for Infusion Therapy. The members of NAIT are national providers of home and alternate site infusion therapy, which includes parenteral and enteral nutrition, as well as national manufacturers of the supplies, drugs, and equipment used in the provision of these therapies.

I appreciate the opportunity to appear before this subcommittee to discuss the administration's Medicare budget proposal as it relates to parenteral and enteral nutrition.

I would like to comment on the prior hearing and State that we, too, support H.R. 345 for reasons I would be happy to elaborate on, if you wish.

Parenteral and enteral nutrition are covered under the prosthetic device benefit of part B of the Medicare program. Payment for these therapies is calculated according to the lowest charge level methodology as mandated by Congress in OBRA 1986.

The administration has sent to Congress a proposal to "establish a fee schedule to pay for parenteral and enteral nutrients and supplies, and to pay for parenteral and enteral equipment under the same fee schedule and methodology used for DME." HCFA has submitted this same proposal in various forms in 1989, 1990, 1991 and 1992, and it has been rejected by Congress each time. We urge Congress to reject it again in 1993.

In explaining our opposition to this proposal, it may be useful if I summarize briefly what parenteral and enteral nutrition are. These therapies are among the most complex treatments offered to Medicare patients outside of acute care institutions.

Until the mid-1970s, these were considered strictly inpatient therapies, but advances in technology, experience, and training now enable Medicare beneficiaries with severe nutrition-related disorders to receive nutritional support, safety and cost-effectively, in the comfort of their homes.

Parenteral nutrition is indicated for those patients whose digestive system does not permit the absorption of nutrients sufficient to maintain adequate strength and weight. In other words, these patients are in danger of starving or suffering other debilitating effects of malnutrition.

Patients on parenteral nutritional therapy receive their daily nutritional needs in a liquid solution pumped into a vein through a surgically-inserted venous catheter or other vascular access device.

Parenteral patients include those suffering from Crohn's disease, short-bowel syndrome, bowel obstruction, severe burns, malabsorption syndrome, pancreatitis, cancer, ulcerative colitis, and AIDS-related malnutrition.

Enteral nutritional therapy involves tube feeding directly into the patient's stomach or intestine. It is indicated for patients whose digestive system functions normally but who are unable to swallow, or who have a gastric obstruction or who cannot otherwise ingest adequate amounts of food and fluids by mouth.

Common causes of these conditions include major surgery of the gastrointestinal tract, mechanical obstruction or malfunction caused by cancer or stroke, a comatose state, or Alzheimer's disease. Many enteral nutrition patients have neurological disorders which prevent the oral intake of food.

The provision of parenteral and enteral nutrition requires clinical expertise. Individual prescriptions for parenteral solutions are compounded under sterile conditions by pharmacists trained in sterile compounding.

Enteral nutrition formulas ordinarily are premixed by the manufacturer and not by a pharmacist.

The pharmacist works closely with the other members of the care team—the physician, nurse, sometimes a dietitian, support and delivery personnel—to carry out the physician's orders and to respond to complications if they arise. Patient response to therapy is monitored by lab tests, and the pharmacist works with the physician to alter the solution if necessary to achieve the desired therapeutic results.

Prescriptions are prepared on a patient-specific basis, with changes in prescriptions occurring as often as weekly.

Nurses spend significant amounts of time with patients, both in person and by telephone. They train patients and their care partners on how to administer the solution, and teach them to care for the catheter site so as to prevent infection.

During the first months of therapy, the nurse may be in daily contact with the patient. The nurse and the pharmacist are, in effect, the front line personnel upon whom the patient relies for instruction, evaluation, advice, troubleshooting, and reassurance.

At this point, Mr. Chairman, there is no question as to the necessity of these services. We urge the subcommittee to review a recent report from the Congressional Office of Technology Assessment, entitled: "Home Drug Therapy Under Medicare." That report spells out quite clearly the need for specially trained nurses and pharmacists in the provision of the infusion therapies.

Accreditation standards of the Joint Commission on the Accreditation of Healthcare Organizations, and quality guidelines developed by the American Society for Parenteral and Enteral Nutrition as well as by NAIT, also described in detail the need and scope of those services.

Having described the therapies, I would like to discuss the serious problems we see with the administration's proposal. While the Medicare statute and regulations are silent on the subject, HCFA interprets the prosthetic device benefit as covering only the nutrients, supplies, and equipment, thus precluding coverage of the nursing and pharmacy services that are integral to the provision of parenteral and enteral nutrition.

It is not surprising that a payment methodology that reflects costs which HCFA does not want to recognize would be viewed as "excessive" by HCFA.

Unfortunately, if only nutrients, supplies and equipment were provided to Medicare patients receiving either parenteral or enteral nutrition, there would be serious, possibly life-threatening, consequences for those patients.

HCFA would like to develop a fee schedule that does not reflect any of the nursing and pharmacy services involved in the safe and effective provision of therapy. This proposal is simply at odds with how parenteral and enteral nutritional therapies are actually provided, or should be provided, especially to the frail elderly population that comprise much of the Medicare PEN patient population.

We believe HCFA has to focus on how at risk patients are to infection and other problems. This proposal would not simply reduce Medicare expenditures for parenteral and enteral nutrition, it would also redefine these therapies so that HCFA, as a regulatory agency, would not need to address issues pertaining to the clinical services and to the quality of care provided to Medicare PEN beneficiaries.

We urge Congress to protect Medicare beneficiaries from this ill-considered proposal.

The current payment methodology is not perfect by any means, but it is based on charge data collected in 1986 which at least indirectly reflect the costs associated with the pharmacy and nursing services provided to parenteral and enteral nutrition patients. Payment rate increases are limited by the CPI-Urban Index, and Congress has frozen payment rates twice since 1987.

We recognize that the Federal budget approved by Congress calls for significant Medicare reductions, and we are prepared to work with this subcommittee and the entire Congress in identifying how fair and proportionate cuts can be achieved.

For the reasons I have described, however, HCFA's particular proposal is neither reasonable nor fair. Despite its proposal, we suspect that HCFA still would want the necessary nursing and pharmacy services to be provided to Medicare beneficiaries, and would rely on the good faith of providers to continue to render these services even as it seeks policies that imply those services do not exist or are not necessary.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF ALAN K. PARVER
NATIONAL ALLIANCE FOR INFUSION THERAPY**

Good morning, Mr. Chairman and members of the Subcommittee. My name is Alan Parver, and I am the president of the National Alliance for Infusion Therapy. The members of NAIT are national providers of home and alternate site infusion therapy, which includes parenteral and enteral nutrition, as well as national manufacturers of the supplies, drugs, and equipment used in the provision of these therapies. I appreciate the opportunity to appear before this Subcommittee to discuss the Administration's Medicare budget proposal as it relates to parenteral and enteral nutrition.

Parenteral and enteral nutrition are covered under the prosthetic device benefit of Part B of the Medicare program. Payment for these therapies is calculated according to the lowest charge level methodology as mandated by Congress in OBRA 1986.

The Administration has sent to Congress a proposal to "establish a fee schedule to pay for parenteral and enteral nutrients and supplies, and to pay for parenteral and enteral equipment under the same fee schedule and methodology used for DME." HCFA has submitted this same proposal in various forms in 1989, 1990, 1991, and 1992, and it has been rejected by Congress each time. We urge Congress to reject it again in 1993.

In explaining our opposition to this proposal, it may be useful if I summarize briefly what parenteral and enteral nutrition are. These therapies are among the most complex treatments offered to Medicare patients outside of acute care institutions. Until the mid 1970s, these were considered strictly inpatient therapies, but advances in technology, experience, and training now enable Medicare beneficiaries with severe nutrition-related disorders to receive nutritional support, safely and cost-effectively, in the comfort of their homes.

Parenteral nutrition is indicated for those patients whose digestive system does not permit the absorption of nutrients sufficient to maintain adequate strength and weight. In other words, these patients are in danger of starving or suffering other debilitating effects of malnutrition. Patients on parenteral nutritional therapy receive their daily nutritional needs for carbohydrates, proteins, vitamins, minerals, trace elements, fats and other nutrients in a liquid solution pumped into a vein through a surgically inserted venous catheter or other vascular access device.

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The provision of parenteral and enteral nutrition requires clinical expertise. Individual prescriptions for parenteral solutions are compounded under sterile conditions by pharmacists trained in sterile compounding. Enteral nutrition formulas ordinarily are premixed by the manufacturer and not by a pharmacist.

The pharmacist works closely with the other members of the care team - the physician, nurse, sometimes a dietitian, support and delivery personnel - to carry out the physician's orders and to respond to complications if they arise. Patient response to therapy is monitored by lab tests, and the pharmacist works with the physician to alter the solution if necessary to achieve the desired therapeutic results. Prescriptions are prepared on a patient-specific basis, with changes in prescriptions occurring as often as weekly.

Nurses spend significant amounts of time with patients, both in person and by telephone. They train patients and their care partners on how to administer the solution, and teach them to care for the catheter site so as to prevent infection. During the first months of therapy, the nurse may be in daily contact with the patient. The nurse and the pharmacist are, in effect, the front line personnel upon whom the patient relies for instruction, evaluation, advice, trouble-shooting, and reassurance.

There is no question as to the necessity of these services. We urge the Subcommittee to review a recent report from the Congressional Office of Technology Assessment, entitled Home Drug Therapy Under Medicare. That report spells out quite clearly the need for specially trained nurses and pharmacists in the provision of the infusion therapies. Accreditation standards of the Joint Commission on the Accreditation of Healthcare Organizations, and quality guidelines developed by the American Society for Parenteral and Enteral Nutrition as well as by NAIT, also describe in detail the need and scope of those services.

Having described the therapies, I would like to discuss the serious problems we see with the Administration's proposal. While the Medicare statute and regulations are silent on the subject, HCFA interprets the prosthetic device benefit as covering only the nutrients, supplies, and equipment, thus precluding coverage of the nursing and pharmacy services that are integral to the provision of parenteral and enteral nutrition. Its current proposal reflects that position. It is not surprising that a payment methodology that reflects costs which HCFA does not want to recognize would be viewed as "excessive" by HCFA. Unfortunately, if only nutrients, supplies and equipment were provided to Medicare patients receiving either parenteral or enteral nutrition, there would be serious, possibly life-threatening, consequences for those patients.

HCFA would like to develop a fee schedule that does not reflect any of the nursing and pharmacy services involved in the safe and effective provision of therapy. This proposal is simply at odds with how parenteral and enteral nutritional therapies are actually provided, or should be provided, especially to the frail elderly population that comprise much of the Medicare PEN patient population. We believe HCFA has not focused on how at risk patients are to infection and other problems. This proposal would not simply reduce Medicare expenditures for parenteral and enteral nutrition, it would also redefine these therapies so that HCFA, as a regulatory agency, would not need to address issues pertaining to the clinical services and to the quality of care provided to Medicare PEN beneficiaries. We urge Congress to protect Medicare beneficiaries from this ill-considered proposal.

The current payment methodology is not perfect by any means, but it is based on charge data collected in 1986 which at least indirectly reflect the costs associated with the pharmacy and nursing services provided to parenteral and enteral nutrition patients. Payment rate increases are limited by the CPI-Urbain Index, and Congress has frozen payment rates twice since 1987. In practice, this methodology has operated as a fee schedule, wherein a provider's actual or customary charges are relevant

only in situations where those charges are lower than the lowest charge level payment rate.

Part of the problem is that the prosthetic device benefit is not a very appropriate coverage vehicle for parenteral and enteral nutrition. If the Medicare home infusion therapy benefit had not been repealed when the Medicare Catastrophic Coverage Act was repealed, we would have a separate benefit that clearly spells out all that is involved in the provision of PEN therapy. While this issue is not before the Subcommittee today, we support re-enactment of that benefit as the most logical, fair, and straight-forward means of regulating all of the infusion therapies.

It is important to note that most Medicare PEN patients do not qualify for nursing care under the Medicare home health benefit because they do not meet the homebound requirement of that benefit. One of our members, a large Medicare-certified home health agency, reports that of its Medicare PEN patient population, only 10% of those patients are on average eligible for services under the home health benefit. Information from our other provider members supports these findings. Clearly, the existence of the Medicare home health benefit does not justify the eradication of services from the PEN payment methodology.

We recognize that the federal budget approved by Congress calls for significant Medicare reductions, and we are prepared to work with this Subcommittee and the entire Congress in identifying how fair and proportionate cuts can be achieved. For the reasons I have described, however, HCFA's particular proposal is neither reasonable nor fair. Despite its proposal, we suspect that HCFA still would want the necessary nursing and pharmacy services to be provided to Medicare beneficiaries, and would rely on the good faith of providers to continue to render these services even as it seeks policies that imply those services do not exist or are not necessary.

We also oppose the proposal to subject parenteral and enteral equipment to the DME fee schedule. This policy change would in effect separate parenteral and enteral pumps from the other components of PEN therapy for the purposes of payment. HCFA sought this statutory change in 1989 and 1992, and we believe Congress should continue to reject this idea.

HCFA contends that PEN pumps are comparable to the items subject to the DME fee schedule. Of course, PEN pumps may be classified as equipment, but that alone does not mean that they fit well within the DME fee schedules. As noted earlier, parenteral and enteral nutrition are complex, invasive therapies, of which the pumps are a significant part. Coverage for either parenteral or enteral nutrition is not based on the use of a pump or any item contained in the DME fee schedules. Rather, it is based on a particular patient's need for nutritional therapy to avoid malnutrition. PEN pumps are used in conjunction with a variety of medical services, supplies, nutrients, and equipment, as dictated by the demands of the treatment regimen for a particular patient.

We believe PEN pumps should be categorized, covered, and reimbursed as what they are - integrated components of the provision of PEN therapy. There is no public purpose served by severing the pumps away from the other aspects of PEN therapy, for either coverage or reimbursement purposes. As with the other aspects of PEN therapy, reimbursement for PEN pumps has been settled for years, due to the 1986 enactment of legislation mandating the use of the lowest charge level methodology. As I noted earlier, annual increases in reimbursement are limited by the application of the inflation-indexed charge limit. In 1989, Congress imposed a ceiling on the number of months Medicare will pay for the rental of these pumps. In short, there currently

exists a national payment ceiling for both monthly rentals and pump purchases. We strongly believe there is no reasonable justification for subjecting PEN pumps to another payment methodology.

We believe we should be working to integrate therapies, not fragment them as HCFA's proposal would do. Many of the problems PEN providers face today stem from the fact that we do not have a comprehensive, integrated benefit that details all of the services used in the provision of therapy. Further fragmenting PEN will only exacerbate those problems, and continue the confusion as to how the therapies should be provided.

My final comment concerns the impact of the changes sought by HCFA. While they are quite technical in nature, they have ramifications far beyond the Medicare program. As the health reform debate moves ahead in the coming weeks and months, there will be intensive scrutiny of existing coverage and payment mechanisms that may serve as models for a new health system. A Medicare model for parenteral and enteral nutrition that has excluded any reference to or accommodation of the clinical services may become the standard under the reformed health care system. This would not be in the best interests of the future patients, both young and old, who may be in need of PEN therapy. Existing quality assurance mechanisms may be ignored by policymakers if PEN becomes regulated as an equipment-driven area of therapy. We urge Congress to consider these consequences in its consideration of the Administration's proposal.

Thank you for the opportunity to address the Administration's proposal. I would be happy to answer any questions you may have.

STATEMENT OF IRENE PAIGE, R.N., AMERICAN ASSOCIATION FOR CONTINUITY CARE, ON BEHALF OF THE HOME CARE COALITION

Chairman STARK. Mrs. Paige.

Ms. PAIGE. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, my name is Irene Paige, and I am representing the Home Care Coalition. I am a registered nurse, a specialist in discharge planning, I am the continuing care coordinator at the George Washington University Medical Center, in addition, I am an active member of the American Association of Continuity of Care.

The Home Care Coalition is a broad based coalition of national associations that believe home care is a vital component of a cost-effective health care system. The coalition came together in January 1991, to communicate the positive aspects of home medical equipment, supplies and services, and to explain to Congress and health policy analysts that cuts in the Medicare part B home medical equipment benefit will adversely affect Medicare beneficiaries.

Mr. Chairman, my nursing practice in discharge planning at the GWU Medical Center requires me to balance the need to reduce the length of stay for patients with the patient's needs for care and the capability to have that care provided at home. During the 1980's, I observed that home care companies developed and maintained a level of performance that allowed consumers and professionals like me to achieve a high level of confidence in the quality and availability of home care.

The support services that are incorporated into the Medicare home medical equipment services benefit are absolutely essential to

assure the availability of quality HME services. These support services range from the expertise of the clinicians, to timely delivery, setup, and education for the patient and family; to logistical and paperwork support for the hospital discharge planner and the prescribing physician; and to the supplier's inventory of the wide variety of products that patients need in the home.

These support services are particularly essential for the patients I work with—patients with AIDS, cancer, elderly patients with other chronic illnesses that need such high-tech equipment as ventilators, respiratory equipment and infusion pumps for intravenous antibiotics, narcotics, and chemotherapy.

The availability of these HME supplier support services has obviously helped my hospital achieve the financial benefit of reduced length of stay because we are confident that our patients are receiving quality HME services in their homes. In addition, the service component is particularly important for those patients who continue to require their equipment after their skilled home health care has been terminated—particularly those patients with chronic diseases who need this ongoing clinical support.

Mr. Chairman, there is much discussion on how to achieve broader health reform objectives for our country. The Home Care Coalition believes we need to use home care as an alternative to institutional care whenever it is appropriate. We need to substitute appropriate care at home for the currently much utilized hospital care. Yet the ability to achieve that objective is threatened by recommendations to continue to reduce Medicare part B home medical equipment, supplies, and services.

The Home Care Coalition appreciates your including us in your hearing on this important subject.

Thank you.

[The prepared statement follows:]

TESTIMONY OF IRENE PAIGE HOME CARE COALITION

I. INTRODUCTION

The Home Care Coalition has been formed with a primary goal to focus on education and communications to its members, policy makers and the public. The participants in the Home Care Coalition believe that in meeting its goals, the Home Care Coalition will contribute to the well being of home care consumers by advancing the concept that home care is a vital component of a cost effective health care delivery system.

The Coalition was formed in January 1991 in response to the need to communicate the positive aspects of the Home Medical Equipment, Supplies and Services (HME) industry. There was and is a need to get the message to Members of Congress and health policy makers that cuts in the Medicare Part B durable medical equipment benefit will adversely affect Medicare beneficiaries. By working collectively, with a unified, broad based group of organizations, the Coalition can communicate information that will improve the understanding of the support structure that the home care industry has put in place.

Home medical equipment, supplies and services companies have put into place in the last ten years a level of performance which has helped beneficiaries and professionals achieve confidence in the quality and availability of home care. To that end, the mission of the Home Care Coalition is to preserve the Medicare Part B durable medical equipment benefit, to support quality home medical equipment, supplies and services, and to improve beneficiary access to these home care services.

II. COALITION SUPPORTS CONGRESS' AND HCFA'S EFFORTS TO ELIMINATE ABUSIVE AND WASTEFUL PRACTICES

The Home Care Coalition has publicly supported the efforts of Congress, the Health Care Financing Administration (HCFA), the Office of Inspector General (OIG) and the General Accounting Office (GAO), to identify and focus resources to combat abusive and wasteful practices affecting the home medical equipment and long term care supplies benefit. Often such practices result from unnecessary complexities of the Medicare program, particularly the administration of the home medical equipment benefit.

While supporting the need to eliminate the opportunity for abusive and wasteful practices, the Coalition has expressed concern that Congressional, HCFA and OIG action be carefully targeted to address the problems and not adversely impact the ability of Medicare beneficiaries to receive timely and quality home medical equipment services.

In the past, Congressional solutions to real or perceived problems have created difficulties of their own. For example, the modality-neutral method of oxygen payment reform enacted in the Omnibus Budget Reconciliation Act of 1987 has had a demonstrable impact reducing the availability of portable liquid oxygen and on the development of new cost-saving technology. Similarly, the broad payment reform for wheelchairs in the Omnibus Budget Reconciliation Act of 1990 appears to be reducing the beneficiary's ability to receive these items in a timely manner.

The existing support services that are incorporated into the Medicare home medical equipment services benefit are absolutely essential to assure the timely availability of quality home care services. These support services range from timely delivery, set-up, and education for the beneficiary and family; to technical, logistical and paperwork support for the hospital discharge planner and prescribing physician; to the supplier's availability in inventory of the wide variety of products patients need in the home. A July 26, 1990 report by Lewin/ICF, "The Home Medical Equipment Industry: An Examination of the Industry's Expense Structure," describes these services and their value to the Medicare program. A copy of this study is attached as Appendix B.

Moreover, a report on cost-effectiveness of home medical equipment services underscores the need for Congress to strengthen the availability of necessary HME services. In a study entitled "Economic Analysis Of Home Medical Equipment Services" (May 1991), Lewin/ICF analyzed three case examples: hip fracture, Amyotrophic Lateral Sclerosis (ALS) with pneumonia, and Chronic Obstructive Pulmonary Disease (COPD). Lewin/ICF concluded that savings of up to \$2,330 per patient episode could be achieved, with annual savings potential of up to \$575 million when home medical equipment is used.

A large and diverse population relies upon home care for a wide variety of medical reasons, and when given a choice, patients prefer to have their health care administered in the home.

III. MEDICARE'S NATIONAL HEALTH CARE REFORM

My 15-year old son is home ill today. Nothing serious. We could tell a couple of days ago that he was coming down with something based on adverse readings from our home VSMS (Vital Sign Monitoring System). We primarily use our VSMS to track prevention-oriented data, such as cholesterol level, calorie intake, temperature, weight, blood pressure, chemical/nutritional balance (based on VSMS analysis of blood and urine samples), and cardiac analysis from our VSMS EKG. But, the daily printout showing 30-day trends indicated that antibodies were forming to combat something. We quickly accessed our PC-based Clinical Indications and Referral System (CIRS). This is an expert system designed for use by those without a medical background. By combining the data from the VSMS along with subjective responses to symptom-related questions, we were advised that my son's clinical indications did not suggest a serious illness, and that a visit to our physician was not necessary at this time. We do, however, need to re-evaluate, based on updated data, every eight hours. . . we are fortunate to have VSMS, CIRS and PRG in our home

The health care system of 2015 described above will arrive someday. Indeed, many features of this system exist today. Medicare must not only reflect the health care delivery system of yesterday and today, but also must not create a chilling effect on the health care delivery system of tomorrow. Indeed, Medicare should provide financial incentives to encourage the continued development of less costly, high-quality alternatives to the traditional way in which health care services have been delivered and/or covered in the United States. We must begin to substitute the order ADMIT TO HOME, for the currently over-utilized one, i.e., ADMIT TO HOSPITAL without requiring a patient to jeopardize health care coverage and in order to maximize patient satisfaction.

The Coalition's home health care proposals are designed to maximize flexibility in coverage of health care services regardless of delivery setting (that is, the hospital, the patient's home, or other appropriate setting) as well as to empower the consumer-patient in the health care decision-making process. With respect to the former, that is, the delivery setting, in order to effectuate one of the main goals of health care reform -- to provide access to high quality, cost-effective care -- medically appropriate health care services and items must be covered not only when delivered in facilities, such as hospitals, but also when delivered in patients' homes or other medically appropriate settings. We must reform the delivery "cubbyholes" established under Medicare where status quo health care delivery in 1965 became the framework, and is unable to adapt quickly to the ingenuity in the home care industry.

We must include in Medicare lessons that have been learned from the private health insurance sector. Indeed, the private sector has been adaptive and creative in its coverage of home health care services in recent years, particularly as a part of its managed care initiatives.

With respect to the latter, consumer empowerment, Medicare needs to include provisions that would empower consumers to share in the health care delivery decision-making process. To further document these objectives, the Home Care Coalition suggests the following basic principles which underlie our home care goals:

1. *Empower eligible individuals* not only with the freedom to choose the types of treatments that they, and their health care professional, believe would best meet the individuals' needs, but also with the freedom to choose the setting where health care are delivered; that is, whether the health care services are provided in a health care facility, in the patient's home, or in other health care settings.
2. *Guarantee individuals' freedom of choice* in selecting the health care provider with whom they are most comfortable by requiring Medicare to provide eligible individuals with access to care from any health care provider in the service area, even if the health care provider is not under agreement with a particular Medicare plan.

3. *Ensure information is provided to individuals that permits them to evaluate on a comparative basis; that is, provide information to Medicare beneficiaries that describes not only the types and outcomes of treatment, but also the types of health care covered by Medicare as well as the settings in which such covered health care services will be delivered and covered.*

The 1991 Lewin/ICF study cited above also found that "full realization of the potential of home health care services and home medical equipment services can achieve significant cost savings as well as improve patient satisfaction." Other reports also have evaluated whether people accept or prefer home health care services. These reports tend to find that people not only accept home care, but also actually prefer receiving health care services in their home when it is medically appropriate.

Health care services provided to patients in the home are cost-effective, permit patients to continue to live independently, provide the least disruption to the family, and function therapeutically as well. That is why it is important not to have Medicare proposals which could reduce the capabilities of home care services. Home care services very often serve the ever-growing number of chronically ill people in America. Consistent with the objective of providing access to efficient and effective health care, health care services provided in the home should not only be included in Medicare benefits, but also should be encouraged.

IV. ADMINISTRATIVE EFFICIENCY: CMN REFORM

The costs of health care administration in the United States consume an increasingly large portion of our country's health care spending. One report estimates that physician office overhead costs accounted for 45 percent of physicians' gross income in the United States (see *The Hassle Factor: America's Health Care System Strangling in Red Tape*, American Society of Internal Medicine, 1990). Another report estimates that U.S. physicians' overhead and billing expenses, excluding malpractice premiums, constituted 43.7 percent of their gross professional income (see *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, The New England Journal of Medicine, May 2, 1991, p. 1253).

The Medicare program is no exception. Recent health care policies have increased the bureaucratic burdens/costs of health care administration. The administrative activities necessary to document care provided to beneficiaries compete with the time available for direct patient care.

A provision of the Omnibus Budget Reconciliation Act of 1990 greatly expended the amount of time a physician must spend to detail the medical equipment requirements of his or her patients. This law, enacted by section 4152(f) of OBRA 1990, requires physicians to complete certificates of medical necessity (CMN) for all items of durable medical equipment (HME). Not only does this impose additional unnecessary administrative burdens on the physician, but the provision is administratively unworkable and unenforceable by HCFA and OIG.

Once a physician determines the medical need for an item of HME, an analysis of patient needs is often conducted by discharge planners, home health agencies and others in consultation with HME suppliers who are more knowledgeable than physicians about the precise technology and type of equipment best needed to meet the patient's specific needs. This information is then provided to a physician, who authorizes its use by completing and signing a CMN. Prior to the OBRA 1990 provision, the supplier would complete the information on the CMN, and forward it to the physician who was still responsible for verifying the information on the CMN and attesting to its accuracy.

As a practical matter, there are currently no incentives, financial or otherwise, for a physician to complete CMNs, nor are there penalties for a physician's failure to comply. Physician failure to complete may ultimately decrease beneficiaries' access to services in a timely fashion.

The correct policy should aim for administrative efficiency while addressing perceived abuses. The correct policy should target abusive suppliers and over utilized items, not penalize physicians, patients, suppliers and discharge planners.

Furthermore, Congress has enacted and HCFA is implementing a number of reforms which will directly address the problems that have encouraged the questionable practices of some suppliers such as carrier forum shopping and improved supplier number systems.

The Home Care Coalition recommends that section 4152(f) of OBRA 1990 be amended so that it applies only to "abused" or "overutilized" items of home medical equipment. Under current law, the physician must complete the certificate of medical necessity (CMN) for home medical equipment. Suppliers are prohibited from distributing to beneficiaries or physicians completed or partially completed CMNs, for the convenience of the physician, for home medical equipment.

Chairman STARK. Ms. Paige, why don't we just include home care in the DRG? The hospital saves money, and it all works just fine.

Ms. PAIGE. Why don't we include it in the DRG payment?

Chairman STARK. Yes, then the hospital is under the incentive to get the people out and get them home.

Ms. PAIGE. We are under that incentive right now. I think it would be very difficult because it would be—right now, there is a variety of services in the community that the hospital works with, and it would seem to me to be—

Chairman STARK. In my district, the hospital owns half of them. That is the rub. It gets a lot of other folks mad.

Ms. PAIGE. Probably. That is not the case in this area that I am particularly familiar with.

Chairman STARK. So George Washington doesn't own an oxygen supply or anything like that?

Ms. PAIGE. No, we don't.

Chairman STARK. Good for you. That is one of the things that has happened in some of the hospitals in my area is that they have—then you begin to suspect what is going on. But you don't think it should be included just in the DRG? You have your appendix out. You go home sooner. The hospital saves money, right?

Ms. PAIGE. I think it may appear on the surface to be easier. But right now we have a variety of competitive quality services to choose from, and what I do and what—my expertise is actually to mix and match that with what is available to what the patient

needs. And it seems to me it would be hard to do that if it was tied in.

Chairman STARK. You just pay for it. I mean, you save money, get them out a day earlier. How much does a day at George Washington cost? A couple thousand dollars?

Ms. PAIGE. Around \$900.

Chairman STARK. \$900, plus, plus?

Ms. PAIGE. Yes.

Chairman STARK. It is cheaper to go home, isn't it? Get them out a day earlier? That is \$900 of home medical services.

Ms. PAIGE. We are working toward doing that now.

Chairman STARK. That is all right.

Mr. Parver, I note your objection to the fee schedule, and I guess in your company, which is a—

Mr. PARVER. Trade association.

Chairman STARK. You are strictly with a trade association. So you can't give me any information as to a company in terms of what percentage of their costs are labor costs as opposed to supplies and so forth. Do you know what it is in your trade association?

Mr. PARVER. We have tried to survey our members about issues like that. And their estimate, depending on the therapy now, is in the range of 30 to 45 percent of their costs are supplies and equipment, and the rest is labor.

Chairman STARK. What do the nurses and pharmacists do generally in your industry?

Mr. PARVER. The pharmacist is the person who prepares the parenteral solution and—

Chairman STARK. They do that by mail?

Mr. PARVER. No, sir. These are not prepackaged at all. Each one has to be compounded on a patient-specific basis. The physician prescribes a parenteral solution, describes what elements and in what ratios should be in that solution. The pharmacist prepares it under sterile conditions, and it is then delivered to the patient.

Chairman STARK. How many days' supply can you keep in the refrigerator?

Mr. PARVER. I am not sure about that. I think it is about a week, I think. It is not very long.

Chairman STARK. There was some indication—and I am somewhat confused—but for two liters of TPN in Florida, Medicaid is paying about \$725 and Medicare is paying about \$2,600, why the variation there?

Mr. PARVER. How much was Medicare paying?

Chairman STARK. Medicare is paying \$2,612.82, to be exact, per week, and Medicaid is paying \$724.08 a week. Why would we get that kind of a variation?

Mr. PARVER. The Medicaid program in Florida has probably taken advantage of some significant cost-sharing or cost-shifting opportunities. Is this for the same service?

Chairman STARK. I am just reading here that for two liters of TPN—which I assume is comparable, and one doesn't have California wine in it where the other has Mogen David. I am saying that this is probably the same juice. Now, I am just guessing that there

is an anomaly there. Maybe you could look into that for me. If it was a few dollars one way or the other—

Mr. PARVER. The Medicaid program's payment for the high tech end of home care has been very low compared to the costs of the care, so it would not surprise me at all to see that the Medicaid rate is so much lower than the Medicare rate.

Chairman STARK. But Medicaid is getting the treatment, right?

Mr. PARVER. They are. I would hope so.

Chairman STARK. I don't know. I presume they are. So that would look pretty attractive to us bean counters. That is a big saving.

Mr. PARVER. It may not be an honest savings, though, because it is being shifted someplace else, and it is probably being shifted to Medicare, and it is probably being shifted to the private sector.

Chairman STARK. Very well. Maybe we could both work together and see exactly what service that is.

You might check with one of your Florida members and see if you could give me those fees, and let's see what they charge the private—in other words, I would be curious—if you got Medicaid, you have got Medicare, then what does one of the principal HMOs or what does Aetna pay?

Mr. PARVER. Well, Mr. Chairman, one of the issues we have there and everywhere, I think, is there is no standard product here. There are no Federal standards. There is no conditions of participation that detail exactly what a quality provider ought to be doing in providing service. And that makes it very difficult to compare two providers or two payers really on the basis of price. One issue we have to determine is what are they getting.

Chairman STARK. Well, the doctor determines that, right, to begin with? I mean, if I need whatever this stuff is infused, injected or whatever, then some doctor, I presume, determines what that ought to be, is that correct?

Mr. PARVER. The doctor ordinarily would determine the need for therapy. Exactly how that therapy is provided is something the doctor should be intimately aware of but is not always so. And that is another issue that goes to the lack of a standard product detailing what the physician ought to be doing.

Chairman STARK. But I guess that this is not the kind of thing that I would decide I need on my own and look in the yellow pages for.

Mr. PARVER. No, sir.

Chairman STARK. It would be something that Ms. Paige might—if I am being discharged from some operation and I can't eat so I need to be fed through a tube for a while, and somebody would determine, the physician I presume, whether they thought, based on whatever you would find out is a discharge plan or my home circumstances were, that I was in a position where with some kind of service I could be released from the hospital—and would the doctor not generally prescribe what I ought to get?

Mr. PARVER. Sure.

Chairman STARK. Miss Paige, who does—the doctor—

Ms. PAIGE. The doctor prescribes it. Certainly, there is a lot of input from, particularly, a pharmacist, a dietician, a nurse as to

what is needed, but the actual components of it are prescribed by a physician.

Chairman STARK. And the physician is the one who decides I can leave or not leave more or less, right?

Ms. PAIGE. More or less.

Chairman STARK. OK. I am just assuming that somewhere in this that the doctor is in charge.

Now, having said that, I suppose there are a variety of ways, maybe not—maybe my wife goes to the hospital, gets trained to take care of the needle. Or maybe somebody decides that I ought to have an RN come to the home and do it depending, I suppose, on whether my wife is shaky or whether—I can understand that there would be a variety of ways in which—

But, ultimately, it would seem to me the physician is the person who figures out whether I am responding to the treatment and all of those other things and I would imagine in some cases would select the provider. Is that not the case, based on experience? No? By whom are your clients referred? From Ms. Paige or to me?

Mr. PARVER. It should be by the physician.

Chairman STARK. Generally, is that what happens in the community? There are doctors who specialize in certain procedures which more often would require infusion. OK.

Mr. PARVER. I didn't finish an answer to your previous question about what does the nurse do. Because one of the issues is the nurse is responsible ordinarily for the training of the patient, and that often begins in the hospital done by the home care provider. Then the nurse interacts with a patient, especially in the beginning, on almost a daily basis, either by telephone or in person. The nurse really is the eyes and ears for the provider and often for the physician because they report back to the physician how the patient is responding to treatment, whether there is an infection that has to be dealt with and so on.

Chairman STARK. Are you looking forward to managed competition so you can bid in the community and see all of these services awarded to one supplier or another?

Mr. PARVER. I think this area is a winner regardless of what the health reform mechanism is because I think, properly done, there is no question the therapies are cost-effective compared to inpatient care. The outcomes will be as good or better than they are in a hospital. I think most patients would prefer to be treated in their homes. So regardless of what the reformed system is, I think the outlook for therapies like this would remain good.

Now, the problem we would have with a particular system that puts a premium on cost versus identification of what it is that enables a provider to provide quality care, that is going to be the crucial issue for us. A system that simply puts providers bidding against each other without a standard measure as to what is a quality provider, that should concern patients and certainly concerns us.

There is a lot of what is going on out there under the rubric of infusion therapy that varies widely, and one of the things we would like to see is some standardization, some identification of the precise services, the quality improvement programs that have to be in place for this to work properly.

Chairman STARK. It sounds to me like you are going to let the doctors make that decision. Arguably, we can't let the providers make the decision. They might not be as objective as someone who didn't have a monetary interest in the outcome of the decision. And so we kind of get back to the doctors again.

The nurses are in that box, the doctors who decide whether the nurses are performing well or not. Whether or not the nurses always agree with that, that is the way the system works. And, again, then I think you are willing to see the doctors in the community lay down the prescription and then bid. They are talking about bids.

You avoided that until the very end of your answer, but I am just saying let's suppose that you have three clients in Mr. Yarbrough's Twin Cities, and one of them is going to get the bid to provide all, let's say, home infusion therapy. Are you comfortable with that?

Mr. PARVER. I would be comfortable if they are bidding in the context of there being a clear idea of what the therapies are.

Chairman STARK. Look, Government for better or worse has been able to solicit bids on the B-2 bomber. They get pretty precise about a pretty complex machine, Star Wars, which they don't understand at all, but they still bid on it.

Now, assuming that we will have some grunts who can write more description than you would ever care to read, let's trust the bureaucracy to be able to provide a whole lot of details. Now, are you comfortable with the idea that of your three or four members in Minneapolis one is going to win and the other three are going to go to work for Giant Drug?

Mr. PARVER. Actually, absent the context that I described and if that context is not capable of being done in a fair and honest way, I would have a problem with that, certainly.

Chairman STARK. Well, I think it would be a fair and honest way. I am just trying to find out whether you like the idea of bidding.

I will tell you, the ophthalmologists don't. There is an argument that one cataract surgery is about the same as another cataract surgery. These guys crank them out. And there has been some serious discussion as to why don't we just take all the cataract surgery in an area and bid it out to one group of—

Mr. PARVER. We have never supported bidding, but what we have—we don't have a problem with something that is akin to bidding, which is the development of networks of providers that for cost and quality reasons are preferred by insurance.

Chairman STARK. Quality lets you out of the box. I am sorry, it is bid like *x* box.

Mr. PARVER. If that is all it is, Mr. Chairman, we would oppose that.

Chairman STARK. Good. I need all the help I can get.

Mr. PARVER. I know you were leading me in that direction, but—

Chairman STARK. That is what is coming. Quality—we don't discuss quality with the AMA. We presume it because they regulate themselves. They have their own licensing. If a doctor isn't a quality doctor, he doesn't get a license. And that is as it should be.

It seems to me we are not competent to judge quality. We have to rely on somebody to do it.

Mr. Yarbrough.

Mr. LIKEN. May I comment on that?

Chairman STARK. Yes—just a minute. Let me get to Mr. Yarbrough first.

Implicit in your testimony—and this is something we have dealt with over time—is that you all would like, I sense, to be licensed, to have some recognition for your specialized services, if not your profession. Is that what I am reading into your testimony?

Mr. YARBROUGH. I think that is an appropriate approach. On conditions of coverage, we would like to have qualified people doing the work.

Chairman STARK. One of the problems we have is that we are not in that business. For better or for worse—and I suspect it is for the better. I think everybody else gets licensed by the States. I think nurses are, aren't they? Chiropractors, acupuncturists, the dentists, surgeons. And we pretty much rely on that.

Mr. KLECZKA. Funeral directors.

Chairman STARK. And we aren't, as far as I know, in the business of doing that, and I think we would be reluctant to create a licensed group by default.

I wouldn't mind it being Federal, but then it ought to be done as a result of whomever those people are going to be in the profession establishing their own group, their own standards, their own educational requirements, and their own licensing and all of that. I hate to take that joy away from the State legislatures so that I—and I have said this before and particularly with regard to your association.

What I am sensing is you would like to be licensed, and yet we are not the ones—and if you were, that would be fine with us. That would simplify a problem that Mr. Parver can't get all of his service suppliers in a row and make them a licensee because there are several groups that provide that. And in your case you are a profession looking for a license, and that would make relative our payment structure—

Mr. YARBROUGH. We haven't taken a formal position on licensing, Mr. Chairman. There are two States that have, in fact, licensing, New Jersey and Mississippi. What we would like to see is a condition of coverage that says you have to have some qualification to do what you do.

There are certain types of braces that do not contain a strong professional service component. Cervical braces can be fit by a number of people. There are some other things. But on hard custom bracing, complex bracing, spinal bracing or long leg braces, as well as complex limbs, you need someone who is very well-qualified.

And this also would prevent people from double-dipping. This is people who could charge an L code fee which includes a strong service component.

Chairman STARK. I have no quarrel with you. I am just saying I don't know how we can help you or that we have the resources to think about beginning a license—I don't know how we would identify. We can't, as much as we might think you are great folks, turn that over to an advocacy group any more than we would turn

over the licensing of physicians to the AMA. They might love that, but I think that that would be beyond what we should be doing.

Jim, you had a question.

Mr. LIKEN. I just had a comment on the bid process.

Probably 60 percent of a home oxygen dealer's revenue is derived from the Medicare program. The quality of the companies—and this is a very competitive industry, is—the competition drives the quality into these companies because if you are not doing the job then the hospital discharge planner refers that patient to the next company or the next company or the next company.

In a bid area, if there is one provider, it is going to drive a lot of the other providers out of the area. So if you come around and are looking for a second time around at this, it just doesn't exist or won't exist. That is what I wanted to comment on.

Chairman STARK. Some of my colleagues have suggested that in terms of HMOs bidding on all the people in a HIPC, the first one wins the bid, and there isn't much sense to the rest of the hospitals sticking around town if hospital A gets all the business. So when you come to rebid the contract you find you have a single source situation. That kind of dries up the competition very quickly.

The closer we get to articulating a specific procedure or service that you are going to provide, the easier it is for us to say—

I will give you a perfect example. I cannot for the life of me figure out why we don't bid dialysis. I mean, it is dialysis, dialysis, dialysis, and we buy it all. We are the only customer virtually. And it just doesn't make any sense because I have a hunch we would save some money. I think eventually that is what will happen. We supervise it. We set the standards. Everybody gets it. It is an entitlement for every resident. You don't even have to be a citizen. I don't know as there is much—some other insurance companies may pay for it if people aren't on Medicare, but basically we pay for it all. It comes inexorably toward the answer that we might not be doing the responsible thing if we didn't bid it. So be it.

Mr. Kleczka.

Mr. KLECZKA. Mr. Chairman, you have asked every conceivable question I have ever thought of, so I have no questions.

Chairman STARK. Fine.

I want to thank the witnesses, I appreciate your participation. We will be looking forward to working with you as this whole issue of reconciliation and reform unfolds over the next few months. Thank you very much.

The hearing is adjourned.

[Whereupon, at 3:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]



AMERICAN ASSOCIATION FOR CLINICAL CHEMISTRY, INC.



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STATEMENT OF THE
AMERICAN ASSOCIATION FOR CLINICAL CHEMISTRY
SUBMITTED TO
SUBCOMMITTEE ON HEALTH
FOR THE HOUSE WAYS AND MEANS COMMITTEE

The American Association for Clinical Chemistry, Inc. (AACC) welcomes the opportunity to comment on President Clinton's FY94 budget proposal relating to Medicare Part B clinical laboratory services. AACC, representing more than 10,000 professional laboratory scientists, is concerned that additional cuts in laboratory payments will adversely affect the quality and availability of laboratory testing services.

AACC realizes that all Americans will be required to make sacrifices to reduce the deficit. Laboratorians have paid, and will continue to pay, their fair share. Over the past decade, there have been a number of changes in Medicare reimbursement to laboratories. The establishment of the fee schedule, the creation and subsequent reduction in reimbursement fee caps and cuts in the annual consumer price index (CPI) update, have resulted in billions of dollars in reduced payments to laboratories for services rendered. The fee cap for example, originally set at 115 percent of the median, has been reduced to 88 percent.

President Clinton is proposing to further reduce laboratory fee schedule payments from 88 percent to 76 percent of the median, and permanently extend the two percent cap on the laboratory fee update. (The CPI was scheduled to increase to 3.5 percent beginning in FY95.) These two cuts alone would reduce payments to laboratories by nearly \$4 billion. We believe these cuts are excessive, considering the sharp reductions laboratories endured during the last decade. We are concerned that the reductions outlined in the President's budget package could jeopardize the financial viability of many laboratories, threatening their ability to provide some services and potentially limiting access to care.

At the same time laboratories are being required to implement new, extremely costly federal regulations, such as CLIA '88 and the OSHA bloodborne pathogen standard. According to government estimates, these two rules alone will cost the laboratory community \$3 billion to implement. In the case of CLIA, the labs are paying all the federal costs too, through user fees. Though AACC supports efforts to improve the quality of laboratory testing and strengthen worker protections, complying with these regulations is expensive.

AACC also opposes the Administration's plan to provide the Secretary of Health and Human Services (HHS) with discretionary authority for reducing laboratory payments. The President's proposal states that "the Secretary of HHS would adjust Medicare payment rates to laboratories to account for technological changes or other market factors." Though we agree that Medicare rates should be periodically adjusted, reflecting both decreases as well as increases in costs, we are concerned that giving sole authority to the Secretary would eliminate the essential, oversight role that Congress now plays in managing health care reimbursement. AACC believes that any future cuts must be the result of consultation between the President and Congress, not solely at the discretion of the Secretary.

Statement to Subcommittee
on Health
April 20, 1993
Page Two

AACC agrees, however, that there are areas of the health care system that could be restructured to eliminate costly and unnecessary medical services. Clinical laboratories are among the most innovative and cost-effective segments of the health care industry, however, constantly developing new and better diagnostic tests to improve the quality of health care and reduce costs. Much of these cost savings, however, are not passed on to the consumer or the third party payor. To correct this inequity, AACC recommends that two practices be addressed in any health reform package: physician self-referral and physician billing for non-Medicare laboratory testing.

Thanks to the persistent efforts of Chairman Stark, the Medicare program currently prohibits physicians from referring laboratory tests to facilities in which they or their families have a financial interest. This prohibition does not apply, however, to non-Medicare patient testing. A study of physician self-referral in Florida indicates that physician-owned laboratories perform more than twice as many tests per patient as non-physician-owned facilities; this practice costs patients and third party payors \$500 million annually. The University of Virginia Medical School published another study confirming these findings. We endorse Mr. Stark's legislation, H.R.345, which would end this costly and unnecessary practice.

The second practice contributing to the escalation of health care costs is physician billing of laboratory testing. Currently, most states permit physicians to mark-up and bill for laboratory tests that they do not actually perform (these tests are referred to other labs). This practice, prohibited by Medicare, contributes to the overutilization of laboratory testing and the inflation of laboratory-related charges. A 1988 survey of 1200 primary physicians, conducted by Market Facts, Inc., reported a physician mark-up rate for laboratory testing of 139 percent. In addition, 16 percent of the physicians charged patients more than three times the price levied by the laboratory performing the tests. AACC believes that federal protection should be extended to third party payors and consumers by eliminating these profit-driven practices.

AACC applauds the Chairman's efforts to contain health care costs by eliminating the incentives that encourage the overutilization of laboratory tests and increase overall health care costs. We believe that extending the physician self-referral and direct billing requirements to non-Medicare testing will reduce the costs of health care more effectively than further reducing the direct payments to laboratories.

We look forward to working with the Chairman and the subcommittee in resolving our current health care crisis. If you have any questions, please call Lemuel J. Bowie, President, at (708) 570-2783 or Pamela A. Nash, Director of Professional, Government and Membership Affairs at (202) 857-0717.



American Association of Clinical Endocrinologists

STATEMENT OF THE AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS TO THE WAYS AND MEANS COMMITTEE SUBCOMMITTEE ON HEALTH FOR THE RECORD OF THE APRIL 20, 1993 HEARING

RE: BUDGET ISSUES RELATING TO CLINICAL LABORATORY SERVICES AND PHYSICIAN OWNERSHIP AND REFERRAL

The American Association of Clinical Endocrinologists (AACE) is pleased to provide this statement for the record of the Ways and Means Subcommittee on Health hearing on budget issues relating to clinical laboratory services and physician ownership and referral arrangements. AACE was founded in the Spring of 1991 to create a unified voice for clinical endocrinologists nationwide on issues affecting health care and the practice of endocrinology. We represent the majority of clinical endocrinologists practicing in this country.

Reduction in the Clinical Laboratory Fee Schedule

The proposed cuts in the Medicare laboratory fee schedule are of concern to endocrinologists, many of whom are struggling to keep their office laboratories open at a time when their costs are increasing due to the OSHA law and the requirements of the Clinical Laboratory Improvements Amendments of 1988 (CLIA). We believe that the Clinton Administration and Congress should reassess the impact of those CLIA costs and reductions in clinical lab testing payments on the ability of endocrinologists and other primary care physicians to provide their patients with quality laboratory testing. If it turns out that many physicians are in fact being forced to close their laboratories due to the high costs of complying with CLIA and lower Medicare clinical lab test payments, Congress should consider modifying the administration's proposal to allow for payments that are sufficient to cover the actual costs that physicians incur in providing their Medicare patients with quality clinical laboratory testing.

To allow for Congress to make an informed judgement, AACE recommends that Congress require HHS to study and report annually to Congress on changes in the number of labs operated by physicians and the impact on beneficiary access to those services, including an assessment of the impact of costs of complying with CLIA, OSHA, and reduced laboratory reimbursement on availability of in-office laboratory testing.

Exemption Needed for "Shared" Clinical Office Laboratories Under the Current Self-Referral Ban

The Clinton Administration as well as Chairman Stark also propose to extend the current ban on physician "self-referrals" which apply to outside (i.e., not in-office) clinical laboratories to other facilities such as imaging centers. AACE supports further restrictions on potentially abusive self-referrals. However, there is also still a missing piece in the current self-referral law which needs amendment -- namely that relating to "shared" clinical office laboratories.

An exemption for "shared" clinical office laboratories was contained last year in H.R. 11, which was vetoed by President Bush, and has been re-introduced as part of H.R. 21, by Rep. Dan Rostenkowski (D-IL). It is essential that Congress promptly enact the shared clinical office laboratory provision in H.R. 21 so that physicians who are in these arrangements can continue to deliver the same convenient, cost-effective high-quality clinical laboratory testing services to their Medicare patients. Otherwise more of these patients will have testing at more expensive facilities (hospitals) where the physician has no direct input into the testing or control over the quality of the results.

Shared clinical laboratories are office laboratories that are shared by several physicians (who are not members of a group practice) to provide clinical lab testing for their own respective patients, usually located in space contiguous to their offices. These are common arrangements,

particularly in endocrinology and other primary care settings, and are often the only way many physicians who are not in group practices can afford to maintain a lab for their patients.

If a shared laboratory exemption is not provided for under current law, physicians will be forced to either form group practices or shut down these shared in-office laboratories. The latter will result in sending Medicare patients to outside facilities – often delaying treatment because of the lag time in receiving test results; and burdening the patient with additional hassles, lost time and added cost. An individual physician trusts the quality of the results from his or her own in-office or shared clinical laboratory much more so than results from an outside commercial laboratory.

In-office clinical laboratories owned by solo physicians and group practices are exempt from the current ban on physician self-referral. Yet, a conflict of interest is no more inherent in a limited shared clinical laboratory arrangement than in a group or solo practice that provides clinical laboratory services to patients. Shared clinical laboratory arrangements are a convenient and cost-effective way to provide quality patient testing in an office. In this time of rising health care costs, it makes no sense to prohibit this practical and economical way of providing laboratory services to Medicare patients.

Physicians have been waiting for over three years for guidance from the Department HHS or Congress regarding shared clinical laboratory arrangements, and none has been provided. Even now, physicians have no way of knowing whether they must restructure their arrangements or whether they will be required to refund Medicare clinical lab payments received since January 1, 1992, the effective date of the law. As a result, many physicians are being forced to form group practices solely for the purpose of providing patient testing, so as to avoid any potential risk associated with the prohibition. This is a completely unnecessary added cost to provide quality patient care. For many endocrinologists, however, the formation of a group practice for the sole purpose of providing patients with laboratory services is simply not feasible. Therefore, many more have closed—or may soon be forced to close—their laboratories. The uncertainty and frustration experienced by physicians about this issue has been compounded by the Department's decision to require shared facilities to pay for separate CLIA certificates (as well as fees, inspections and proficiency testing) for each physician in a shared arrangement.

Recently, a coalition of physician organizations sent the attached joint letter supporting the shared laboratory exemption in H.R. 21 and urging Congress to resolve the shared laboratory problem at the earliest opportunity this year. This coalition includes our organization – the American Association of Clinical Endocrinologists – as well as the American Medical Association, American Academy of Family Physicians, American Society of Internal Medicine, American College of Physicians, American College of Rheumatology, American Society of Hematology, American Society of Clinical Oncology, American Academy of Dermatology, American College of Obstetricians and Gynecologists, and the Joint Council of Allergy and Immunology.

The absence of a shared laboratory exemption to the self-referral ban presents an enormous problem that is already having a negative impact on physicians' ability to provide medically necessary laboratory tests for their patients. AACE urges Congress to enact the shared clinical laboratory provision in H.R. 21, modified to eliminate the grandfather clause that limits the exemption only to those laboratories in existence prior to June 26, 1992.

The American Association of Clinical Endocrinologists (AACE) appreciates this opportunity to present our views.

Attachment

aaceclab.letter.doc

April 22, 1983

The Hon. John D. Dingell
2328 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Letter sent to Senate Fin.
Comm., House Ways and Means,
and House Energy and Comm.,
encouraging the enactment of
shared laboratory prov. in
HR 21.

Dear Representative Dingell:

We urge you to seek enactment of the shared clinical laboratory exemption to the Stark prohibition on physician self-referral (Pub. L. 101-508), contained in H.R. 21, at the earliest possible opportunity this year. The absence of a shared laboratory exemption to the Stark ban presents an enormous problem that may have a negative impact on physicians' ability to provide medically necessary laboratory tests for their patients. This problem needs to be resolved immediately.

Shared laboratories are office laboratories that are shared by several physicians to provide testing for their own respective patients, usually located in space contiguous to their offices, but which do not otherwise meet the definition of a group practice. These are common business arrangements, particularly in primary care settings, and are often the only way many physicians can afford to deliver in-office testing services. If a shared laboratory exemption is not enacted, a large number of physicians will be forced to shut down their in-office laboratories and to send their Medicare patients to outside facilities—causing the patient added time, effort and expense—to obtain the same services.

Congress passed such a shared laboratory exemption last year as part of H.R. 11. Except for President Bush's veto, this exemption would have been enacted into law. This exemption has been re-introduced as part of H.R. 21, introduced by Rep. Dan Rostenkowski (D-IL). We urge you to seek enactment of the exemption in H.R. 21, modified to eliminate the grandfather clause that limits the exemption only to those laboratories in existence prior to June 28, 1992. Clinical laboratories owned by solo physicians and group practices are exempt from the Stark ban. We firmly believe that a conflict of interest is no more inherent in a shared laboratory arrangement than in a group or solo practice that provides laboratory services to patients. Shared laboratories are a convenient and cost-effective way to provide quality patient testing in an office. In this time of rising health care costs, it makes no sense to prohibit this practical and economical way of providing laboratory services to Medicare patients.

Physicians who participate in laboratory-sharing arrangements have been waiting in limbo for more than a year to find out whether or not they can continue to provide in-office testing services for their patients. Many are being forced to form group practices solely for the purpose of providing patient testing, so as to avoid any potential risk associated with the Stark prohibition. Many more have closed their laboratories. The Clinical Laboratory Improvement Amendments (CLIA) regulations have complicated this issue even more because HCFA is requiring shared facilities to pay for individual CLIA certificates (as well as fees and inspections) for each physician in a shared arrangement. The reason given for this unfair policy is that shared laboratories are prohibited under the proposed Stark rule.

HCFA officials indicate that the agency will not release a final rule implementing the Stark law until they receive clarification from Congress regarding the shared laboratory issue. The agency is well aware that the failure of the Stark regulations to protect certain types of shared laboratories is a significant problem—over 50 percent of the comments received on the proposed rule addressed the need for a shared laboratory exemption—but says the matter needs to be corrected legislatively. Since the Department of Health and Human Services (HHS) does not believe that it has the authority to grant a regulatory exemption for shared labs, it is essential that Congress promptly enact the shared laboratory provision in H.R. 21. Quick action would ensure that physicians who are in shared laboratory arrangements would be able to continue to deliver the same high-quality clinical laboratory testing services to their Medicare patients that they have in the past.

Thank you for your consideration of our concerns. We look forward to working with the Committee on this issue.

Sincerely,

American Academy of Family Physicians
American Association of Clinical Endocrinologists
American College of Physicians
American College of Rheumatology
American Medical Association
American Society of Hematology
American Society of Internal Medicine
American Society of Clinical Oncology
American Academy of Dermatology
American College of Obstetricians and Gynecologists
The Joint Council of Allergy and Immunology

TESTIMONY OF AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

As the professional association that represents over 25,000 certified registered nurse anesthetists (CRNAs), which is 96% of the nurse anesthetists in the United States, the American Association of Nurse Anesthetists (AANA) appreciates the opportunity to provide testimony regarding anesthesia payment. While the Committee has not included a single payment for the anesthesia care team in its current budget reconciliation package, the AANA would like to be on record regarding this issue in case it is considered at a later time.

AANA SUPPORTS ANESTHESIA REFORM

The AANA supports the need for health care reform in this country, due to skyrocketing health care costs and lack of access to health care by millions of Americans. We believe that anesthesia providers must do our part in terms of helping to reform inefficiencies in the anesthesia system that result in unnecessarily high federal expenditures. But as we all struggle with how anesthesia reform should occur, please keep in mind the important role that CRNAs play in providing patients access to safe, cost-effective anesthesia services.

PPRC RECOMMENDATION ON PAYMENT FOR THE ANESTHESIA CARE TEAM

The Physician Payment Review Commission (PPRC) Annual Report to Congress, 1993, included a chapter on "Payment for the Anesthesia Care Team". It found that an anesthetic provided to a Medicare patient by an anesthesia care team, comprised of a CRNA and an anesthesiologist, can cost 140% versus the 100% cost if a solo anesthesiologist provided the anesthetic. The Commission's recommendation to Congress was that Medicare payments for the team should be capped at 120% of the payment to the solo anesthesiologist in the first year, with the payment being split 50/50 between the CRNA and anesthesiologist. For the next four years the cap should be reduced by 5%, such that the permanent cap would be at 100% of the payment to the solo anesthesiologist, with the payment being split 50/50 between the two providers. The AANA supports a service-based reimbursement policy in which payment for the anesthesia service would be 120% of the solo anesthesiologist cap when there are two providers involved in a single case. However, we believe that the division of the payment for the two providers should be determined at the local practice level, not via a federally imposed 50/50 split.

AANA SUPPORTS ELIMINATION OF TEFRA CONDITIONS OF PAYMENT

The AANA is pleased that the PPRC chapter stated that the Health Care Financing Administration (HCFA) should consider whether to review the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) mandated conditions of payment that anesthesiologists must fulfill in order to be paid by Medicare for medically directing CRNAs, to see if modifications of the conditions would permit greater efficiencies without decreasing quality of care.

The Medicare Carriers Manual details the TEFRA criteria that anesthesiologists must meet to be paid for medical direction as follows:

Medical direction is a covered service only if the physician:

- Performs a pre-anesthesia examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitors the course of anesthesia administration at intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care.

The TEFRA payment conditions came about because of abuses to the system by some anesthesiologists who were making windfall profits by billing for supervising CRNAs when the anesthesiologists were not even in the hospital. The TEFRA conditions were adopted as conditions of payment for anesthesiologists, specifically they were to place anesthesiologists in positions of accountability for the services they were claiming to provide as they worked with and/or employed CRNAs. The TEFRA conditions have been inappropriately interpreted by most people as quality of care standards instead of conditions for reimbursement of physicians, which was the original intent. In describing the medical direction criteria in the March 2, 1983 Federal Register, HCFA stated that they "should not be interpreted as standards of practice or standards of quality, but rather as a description of those elements of common medical practice that are expected to be present when a physician has significant involvement with an individual patient."

TEFRA Conditions Restrict Full Scope of CRNA Practice

Today, the AANA believes the TEFRA conditions have had a profound and adverse effect on CRNA practice and the costs of anesthesia services to Medicare Part B and its beneficiaries. They have unduly restricted the full scope of CRNA practice by not allowing CRNAs to perform all the components of an anesthesia service that they are legally authorized to perform. The TEFRA conditions have also caused disruption in the flow of cases through a surgery schedule when the whole surgical team has to wait for the availability of an anesthesiologist to start a case, even though the CRNA is quite capable of doing the procedures alone. For example, in a Texas hospital the need to wait 20 minutes for an anesthesiologist to show up for induction (the insertion of a breathing tube into the patient's trachea) is estimated to have cost \$160 for operating room time (\$8.00 per minute x 20 minutes), plus the cost for CRNA time. In another Michigan example, an uncomplicated patient undergoing an arthroscopy procedure under a mask general anesthetic must wait for his case to begin until the anesthesiologist leaves another case where the patient is undergoing emergence (the extubation of the breathing tube from the patient's trachea), even though both patients are stable. These examples reinforce the fact that the decisions as to what level of involvement an anesthesiologist should have in each case should be made at the local practice level based on facility preferences and patient circumstances.

If providers working alone do not need federal criteria to tell them how to practice, then why should CRNAs and anesthesiologists in a collaborative practice need any federal criteria, such as TEFRA, to tell them how to practice? The federal government should not have a role in micromanaging anesthesia practice to the level that it now does under the TEFRA conditions.

If an anesthesiologist does not fulfill all the TEFRA conditions, for example, if he or she is not physically present for emergence, then he or she can not be paid for medical direction. TEFRA precludes an anesthesiologist who has fulfilled the other TEFRA conditions, but is absent for emergence, from receiving a medical direction payment for that case. Under the current TEFRA conditions, that anesthesiologist would not qualify for payment despite the work effort involved in that case and the resultant liability exposure. The AANA doubts that our anesthesiologist colleagues find all of the existing TEFRA conditions conducive to their busy practices or favor the federal government's intrusion into their practice decisions. They clearly must be concerned about fraudulent billing for medical direction if they have not met all of the TEFRA conditions.

TEFRA Conditions Perpetuate Costly 2:1 Practice Ratio

Most importantly, the TEFRA conditions have often been erroneously interpreted as requiring anesthesiologists to medically direct no more than two CRNAs, called a 2:1 practice ratio. This has led to the hiring of, or contracting with, more anesthesiologists to provide medical direction and the need to pay two anesthesia fees in more cases (the CRNA fee and the medically directing anesthesiologist fee).

The AANA does not believe that all CRNAs must practice with anesthesiologists in a 2:1 practice ratio. The AANA continues to support CRNAs in whatever practice they choose, but we believe that the marketplace should decide what CRNA/anesthesiologist practice

arrangements should be. The 2:1 practice ratio model should not be perpetuated by federal payment policy. The AANA believes that CRNAs may choose to work under the medical direction of an anesthesiologist, or not, as they see fit. Some CRNAs view their non-medically directed services as being the most cost-effective way of providing anesthesia care. Others must work under the medical direction of an anesthesiologist because of the particular hospital or medical staff philosophies.

While approximately 75% of CRNAs are employed by a hospital or CRNA/anesthesiologist group, the 1991 AANA membership survey data shows that almost 15% of CRNAs are self-employed, work for CRNA groups, or work as locum tenens (providing vacation/temporary relief). Patient outcomes data has consistently shown that the anesthesia provided by solo CRNAs is of the same high quality as that provided by CRNAs who work with anesthesiologists or by solo anesthesiologists. Therefore, there is obviously no safety or quality reason to enforce an arbitrary 2:1 practice ratio, when CRNAs and anesthesiologists working alone provide quality anesthesia care.

Preservation of a system wherein anesthesiologists only have to medically direct two CRNAs to be paid as much as if they did a case alone, regardless of the complexity of the cases or patient acuity levels, is not the most efficient, cost-effective allocation of resources. In 1991, the PPRC recommended that "fees paid to an anesthesia care team be capped at the solo anesthesiologist's level because there was neither a clinical justification nor a demonstrated benefit to the patient in using the care team. Although there may be selected instances when additional hands that are available with a care team are needed to provide the service, the decision to use a care team largely appears to be determined by practice style preferences of providers and hospitals."

The AANA agrees with this PPRC statement. We believe that certain types of complex cases or certain patient acuity levels warrant more than one pair of hands. As discussed in previous Commission meetings, however, a 2:1 ratio wherein an anesthesiologist medically directs only two CRNAs may be inefficient in less complex cases. The core issue that PPRC did not address is under what circumstances is it necessary to have two anesthesia providers involved in a case?

Data Quantifying CRNA and Anesthesiologist Work Effort

There is very little data available that quantifies the work performed by CRNAs and anesthesiologists collaborating in a case. Some preliminary data quantifying the work of CRNAs and anesthesiologists has been gathered via a 1991 AANA membership survey and a 1992 pilot study of medical direction in one California hospital.

The 1991 AANA membership survey asked our members about the involvement of CRNAs and anesthesiologists in the anesthesia process. The AANA survey data showed that those CRNAs who were medically directed by an anesthesiologist still performed the majority of the anesthesia components in a case. In addition, a pilot study was completed in 1992 at a large southern California county-financed acute care hospital, which documented and described the function and roles of CRNAs and anesthesiologists in clinical practice as members of the anesthesia care team. Medical direction under the anesthesia care team was evaluated by both CRNA and anesthesiologist team members, as it occurred in the delivery of each individual anesthetic. The California study results showed that CRNAs and anesthesiologists perceived that only 18-24% of the cases within the hospital benefited from either two providers or medical direction.

The PPRC ignored the data that was available regarding the work effort of CRNAs and anesthesiologists involved in an anesthesia care team and instead used incentive-based logic for the purposes of perpetuating the current anesthesia care team 2:1 practice ratio model. The PPRC payment recommendation is based on the need to continue a 2:1 practice ratio. On the contrary, the AANA contends that the work effort of an anesthesiologist medically directing CRNAs should be based on the complexity of the case or the patient acuity level. A flat 50/50 split of 120% (or 100%) of the solo anesthesiologist rate in order to perpetuate a 2:1 practice ratio ignores the reality that the amount of anesthesiologist work effort involved in different

cases varies greatly.

To further compound the problem, because there are so many anesthesiologists now practicing in large urban hospitals, there is a growing trend of a 1:1 practice ratio occurring even in uncomplicated patient cases. This 1:1 practice ratio in large urban hospitals is alarming in light of the shortage of anesthesia providers in rural hospitals. Solo CRNAs currently provide 85% of the anesthesia in rural hospitals, but there is still an anesthesia provider shortage in rural areas. The AANA believes that a more prudent public policy would be to let the decisions regarding CRNA/anesthesiologist involvement in a case and payment for the collaborating CRNA/anesthesiologist be made at the local practice level. If this type of a change in payment policy results in the elimination of 1:1 and 2:1 practice ratios in uncomplicated cases and the displacement of some anesthesia providers from large urban hospitals to rural areas, that is a societal bonus.

PPRC's recommendations have always been viewed with great respect by Congress because they have been based on sound data. Unfortunately, the PPRC recommendation on payment for the anesthesia care team is not backed up by work effort data.

Circumstances Behind Adoption of TEFRA Conditions Are Nonexistent Today

The TEFRA conditions were adopted at a time when there was billing by "ghost" anesthesiologists who were not even in the hospital. The circumstances that may have driven the adoption of TEFRA 10 years ago no longer exist for several reasons. First, there are more anesthesiologists in the market to provide coverage. Second, in these times of cost containment, no hospital or surgeon is going to tolerate an anesthesiologist fraudulently billing for "ghost" services. Third, anesthesia is safer today. Ten years ago mortality due to untoward events in anesthesia was quoted as occurring in 1:20,000 cases, a recent study now estimates that it is 1:200,000 cases. This increased safety is due to technological advances in monitoring, as well as improved anesthetic drugs. Fourth, the ASA has adopted the TEFRA conditions as professional standards. It is the role of that association, not the federal government, to enforce such professional standards. It is inappropriate to have the TEFRA conditions defined in federal payment policy when they arbitrarily create a demand for increased numbers of anesthesiologists and have the effect of restricting the full scope of practice of CRNAs. In summary, the circumstances that may have driven the adoption of TEFRA conditions as a way for the government to oversee medical decision-making in the anesthesia process are nonexistent today. For the above reasons, the AANA wants the TEFRA conditions eliminated.

STEPS THAT MUST OCCUR WITH ANESTHESIA PAYMENT REFORM

1. A 50/50 split of 120%, transitioning down to 100%, of the solo anesthesiologist rate, in the absence of the repeal of the TEFRA conditions, will not correct the problem of the costly overutilization of anesthesiologists.
2. A 50/50 split of 120%, transitioning down to 100%, of the solo anesthesiologist rate, especially if adopted by all insurers, could cause a disruption in CRNA practice arrangements. If CRNAs do not have a level playing field in terms of equitable access to clinical privileges, they cannot compete. Therefore, institutions that receive federal funding must be restricted from discriminating against CRNAs, as a class of provider, in the awarding of clinical privileges.
3. There are currently 92 accredited nurse anesthesia education programs in the U.S. Many hospitals look closely at the funding they receive for CRNA-employee services when deciding to initiate or continue their nurse anesthesia education program. This is because many hospitals already receive insufficient Medicare payment to cover the costs of hospital-employed CRNAs who serve as clinical instructors to nurse anesthesia students. This is due to the inequities in how Medicare pays for the supervision of anesthesiology residents versus the supervision of nurse anesthesia students. Until December 31, 1993, teaching anesthesiologists can be paid full base and time units for supervising two cases

involving anesthesiology residents. CRNA clinical instructors can be paid full base and time units for supervising only one case involving a nurse anesthesia student, because it is viewed as if the case is personally performed by the CRNA. However, CRNA clinical instructors are qualified to supervise up to two nurse anesthesia students and they should be paid for doing so. CRNA clinical instructors must be allowed to receive Medicare payment for supervising two nurse anesthesia students.

Further decreases in Medicare payments to hospitals that employ medically-directed CRNAs may compound the existing funding inequities hospitals experience with nurse anesthesia education programs. This could have a negative effect on the future number of nurse anesthesia education programs and the future number of CRNA graduates, thus contributing to the already severe shortage of CRNAs.

The AANA believes that any future change to Medicare payment for anesthesia should have a neutral effect relative to the preparation of anesthesiology residents and nurse anesthesia students. There should be equitable treatment in terms of payment for the supervision of anesthesiology residents and nurse anesthesia students by anesthesiologists and/or CRNAs.

4. The TEFRA 1982 law also limited anesthesiologists to medically directing CRNAs in no more than four concurrent cases. However, there is no safety or quality reason to enforce an arbitrary ratio on practice arrangements when CRNAs and anesthesiologists regularly provide quality anesthesia services when working alone. If anesthesia providers working alone provide safe anesthesia services, then ratio restrictions on practice arrangements are illogical. The AANA wants all payment policy requirements related to ratios of CRNAs to anesthesiologists eliminated. Specifically, this would eliminate the current restriction that anesthesiologists will be paid for medically directing no more than four CRNAs concurrently. In addition, it would eliminate the 10%, 25%, 40% reduction in base units and use of 30 minute time units in cases where the anesthesiologist medically directs two or more CRNAs.

AANA RECOMMENDATIONS

If a decision is made to adopt a payment reform for collaborative practice between CRNAs and anesthesiologists, the AANA will support such an approach only if the following five actions occur concomitantly:

1. Eliminate the current Medicare Conditions of Participation (TEFRA 1982) which an anesthesiologist must fulfill in order to be reimbursed for medical direction of CRNAs.
2. Restrict institutions that receive federal funding from discriminating against CRNAs, as a class of providers, in the awarding of clinical privileges.
3. Establish a payment methodology for an anesthesia service which involves one or more providers supervising nurse anesthesia students. There should be two payment formulas:
 - a) Payment for the anesthesia service when there are two providers (e.g. CRNA and anesthesiologist) supervising up to two nurse anesthesia students would be 120% of the solo anesthesiologist cap.
 - b) Payment for the anesthesia service when there is a solo teaching CRNA supervising up to two nurse anesthesia students would be under the same Medicare payment methodology that is used to reimburse a solo anesthesiologist who is supervising up to two anesthesiology residents.
4. Eliminate all payment policy requirements related to ratios of CRNAs to anesthesiologists, specifically:

- a) Eliminate the current restrictions that anesthesiologists will be paid for medically directing no more than four CRNAs concurrently.
 - b) Eliminate the 10/25/40 percent reduction in base units and use of 30 minute time units for Medicare payment in cases where the anesthesiologist medically directs two or more CRNAs.
5. Establish a service-based reimbursement policy in which payment for the anesthesia service would be 120% of the solo anesthesiologist cap when there are two providers involved in a single case. Two providers will be paid by Medicare when: 1) both providers are physically present in the facility; and 2) both providers participate in the care of the patient.

The division of payment for two providers would be determined at the local practice level. Distribution of the payment would be made under three payment formulas:

- a) When the CRNA is employed by, or under contract with, a hospital or other entity, and provides the service in collaboration with a second anesthesia provider (CRNA or anesthesiologist) who is not employed by, or under contract with, that entity, (e.g. self-employed), the payment would be made to the hospital or other entity where the service was performed. The payment to each provider would be made on the basis of a predetermined agreement.
- b) When the CRNA is employed by, or under contract with, a CRNA or physician group, and provides the service in collaboration with a second anesthesia provider (CRNA or anesthesiologist) who is not employed by, or under contract with, that group, the payment would be made to the hospital or other entity where the service was performed. The payment to each provider would be made on the basis of a predetermined agreement.
- c) When the CRNA is employed by, or under contract with, a CRNA or physician group, and provides the service in collaboration with a second anesthesia provider (CRNA or anesthesiologist) who is also employed by, or under contract with, that group, the payment would be made to the CRNA or physician group. The payment to each provider would be made on the basis of a predetermined agreement.

SUMMARY

The AANA believes that there must be reform in anesthesia payment under Medicare. However, any policy that is adopted regarding a single anesthesia payment for collaborative practice between CRNAs and anesthesiologists must also mandate the elimination of the TEFRA conditions which an anesthesiologist must fulfill to be reimbursed for the medical direction of CRNAs and the elimination of all requirements related to practice ratios of CRNAs to anesthesiologists. In addition, the policy must restrict institutions from discriminating against CRNAs seeking access to clinical privileges. Finally, it must fairly reimburse CRNAs for their role in the delivery of anesthesia and the supervision of nurse anesthesia students.

The AANA appreciates your consideration of our views and looks forward to working with the Committee on anesthesia payment reform.

APPENDIX - ECONOMIC IMPACT OF THE PPRC RECOMMENDATION

Analysis of current payments to solo anesthesia providers versus the anesthesia care team reveals that Medicare pays more for cases performed by an anesthesia care team than those performed by solo providers (see Table 1 for a sample hernia case). At the high end, anesthesia care team payments for a case may be as much as 40% more than the amount a solo anesthesia provider would be paid for that case.

Current Payment

The sample 90 minute hernia case, in Table 1, using a solo CRNA or a solo anesthesiologist would cost \$169.10 under the following formula:

4 base units (complexity of procedure) + 6 time units (1 time unit per 15 minutes) x \$16.91 (solo provider conversion factor) = \$169.10

The sample 90 minute hernia case, in Table 1, using a 2:1 practice ratio would cost a total of \$224.96 under the following formula:

4 base units + 6 time units x \$11.35 (medically directed CRNA conversion factor) = \$113.35 for the medically directed CRNA;

3.6 base units (10% reduction in base units for medical direction of two cases) + 3 time units (time units are halved) x \$16.91 (solo conversion factor) = \$116.61 for the anesthesiologist;

The CRNA and anesthesiologist payments are \$113.35 + \$116.61 = \$224.96 Total (this amount is 33% higher than the \$169.10 cost if a solo provider had done the case).

PPRC Recommended Payment

Applying the PPRC recommendation of a total payment at 120% of the solo anesthesiologist rate, split 50/50, to the sample hernia case would mean that the team would receive \$202.92 (120% of the solo rate of \$169.10). The CRNA would receive half of \$202.92, which equals \$101.45. The CRNA payment of \$101.45 is a 10% cut from the current medically directed CRNA payment of \$113.35.

Applying the PPRC recommendation of an eventual total payment at 100% of the solo anesthesiologist rate, split 50/50, to the sample hernia case would mean that the team would receive \$169.10 (100% of the solo rate of \$169.10). The CRNA would receive half of \$169.10, which equals \$84.55. The CRNA payment of \$84.55 is a 25% cut from the current medically directed CRNA payment of \$113.35.

Anesthesiologists medically directing two sample hernia cases would break even under the PPRC recommendation of 100%, split 50/50. They would make \$84.55 for each case, for a total of \$169.10, which is what they would have been paid if they had done the case alone. If they medically directed more than two cases, they would be paid more than they would be paid for doing one case alone.

Anesthesiologists medically directing two sample hernia cases would actually make more money than if they did the case alone under the PPRC recommendation of 120%, split 50/50. They would make \$101.45 for each case, for a total of \$202.90, which is 20% more than the \$169.10 that they would have been paid if they did one case alone.

But the major difference between CRNAs and anesthesiologists under the PPRC recommendation is that a CRNA can only participate in one case at a time, while an anesthesiologist can medically direct several cases. If anesthesiologists increase the number of cases that they medically direct, they could actually make more money under the PPRC recommendation than they do now. However, CRNAs will clearly lose under the PPRC recommendation: an average 10% cut under a 50/50 split of 120% of the solo anesthesiologist rate or an average 25% cut under a 50/50 split of 100% of the solo anesthesiologist rate. Anesthesiologists have a potential to gain money under the PPRC approach, but for CRNAs it

is a lose/lose proposition. The AANA cannot support payment reductions to CRNAs which could cause potential serious disruptions in practice and provide less support for nurse anesthesia educational programs. Instead, the AANA believes that the payment decision should be made at the local level and the marketplace should decide what CRNA/anesthesiologist practice arrangements should be, not some arbitrary federal reimbursement policy.

COMPARISON OF CRNA AND ANESTHESIOLOGIST SALARY INCREASES

The PPRC report notes that because CRNA salaries and fringe benefits have risen in recent years, CRNA payments are a more logical target for any future cuts. The AANA disagrees because any increases in CRNA salaries in recent years are due predominantly to the severe shortage of CRNAs in the country.

In addition, while CRNA salaries have risen in recent years, they have not increased nearly as dramatically as have anesthesiologist salaries. Data in the 1992 AANA membership survey reported that the mean gross annual salary/income for full-time CRNAs employed by hospitals for calendar year 1990 was \$75,233. The comparable figure for full-time CRNAs employed by CRNA/anesthesiologist groups was \$71,079. The mean gross annual salary/income figures included straight salary, on-call, overtime, and bonuses.

Medically directed CRNA salary/income increases pale in comparison to salary increases for anesthesiologists as reported in the April 1992 Anesthesiology News. It noted that "[A]ccording to a nationwide survey of physicians and allied health care workers in medical groups, direct median compensation for anesthesiologists in 1991 was \$220,800, up 19.4% from \$185,000 two years ago." The \$220,800 direct compensation included taxable salary, incentive payments, research stipends, honoraria and taxed profit sharing distribution; it did not include fringe benefits. In terms of median fringe benefits, anesthesiologists in 1991 also received \$30,000 in single specialty groups and \$22,256 in multispecialty groups. Fringe benefits included retirement plan contributions, life and health insurance, automobile or any employer contributions to a 401K or KEOGH Plan.

INCREASED CRNA RATES NEEDED TO PROVIDE EQUITY

The PPRC report also assumes that because CRNA Medicare conversion factors have increased in recent years, while anesthesiologist conversion factors have decreased, the CRNA conversion factors should therefore be the ones reduced under anesthesia payment reform. CRNA Medicare conversion factors have risen in recent years to correct a huge inequity in the CRNA conversion factors that HCFA established under the CRNA direct reimbursement law. OBRA86 directed HCFA to develop a CRNA fee schedule under which total payments for CRNA services would equal the estimated total amounts that would have been paid in 1989, if the services were included as inpatient hospitals services. In January 1989, HCFA published an interim CRNA fee schedule that was 35% below what would have been paid under a continued Medicare Part A pass-through.

HCFA's low CRNA conversion factors occurred for two reasons. First, there was a technical error in the fee schedule legislation. A two-step budget neutrality requirement forced HCFA to calculate the CRNA conversion factors using only the monies paid for CRNA services under Part A (which represented only 65% of the total CRNA costs). Left out of the equation were the other 35% of costs of CRNAs who were physician-employed. Therefore, the interim CRNA fee schedule attempted to pay 100% of CRNAs with only 65% of the money that had paid out for CRNA services in the previous year. Second, HCFA admittedly undervalued CRNA services by not using the most current and accurate AANA data. This undervaluing problem was eventually corrected in the CRNA final fee schedule published on July 31, 1992, and financial corrections were made by HCFA. However, the only way to remedy the technical error in OBRA86 regarding physician-employed CRNA costs, that resulted in inequities in the 1989 interim fee schedule, was for AANA to return to the legislative arena to secure fair Medicare CRNA conversion factors.

When HCFA was developing the 1989 CRNA conversion factors, AANA had repeatedly contended that the average amount per unit that would have been paid under a cost-based system in 1989 for a non-medically directed CRNA was \$21.83; the average amount per unit for a medically directed CRNA was \$13.85. These \$21.83 and \$13.85 figures were the basis for the legislation in the 102nd Congress which sought a \$21.00 conversion factor for non-medically directed CRNAs and a \$14.00 conversion factor for medically directed CRNAs. AANA contended that the \$21/\$14 fee schedule would more fairly approximate what Medicare would have paid in 1989 if the CRNA Medicare direct reimbursement hadn't been enacted.

Congress agreed with AANA on the need to increase CRNA conversion factors. OBRA90 included statutorily-determined Medicare CRNA conversion factors, effective January 1, 1991. (See Appendix 7) While the original AANA-supported legislation in the 102nd Congress would have created a national Medicare CRNA payment rate of \$21 per unit for non-medically directed CRNAs and a \$14 per unit for medically directed CRNAs, our efforts were stymied by the severe budget deficit facing the nation. Congress was only willing to accept a fee schedule proposal that would reimburse non-medically directed CRNAs at the same level that anesthesiologists would be in 1996, at the end of the RBRVS transition. At that time, anesthesiologist services were estimated to be, on average, 18% overvalued. It was envisioned that the 1990 anesthesiologist average conversion factor of \$20.42 would be gradually decreased under RBRVS until in 1996 it would reach 82% of \$20.42, which is \$16.75.

Non-medically Directed CRNA Rates

Therefore, the non-medically directed CRNA conversion factors were set to begin in 1991 at \$15.50 and increase \$0.25 per year until they reached \$16.75 in 1996 (adjusted by geographic indices). The \$16.75 is the same rate that anesthesiologists were predicted to receive in 1996.

1991 -	\$15.50
1992 -	\$15.75
1993 -	\$16.00
1994 -	\$16.25
1995 -	\$16.50
1996 -	\$16.75

Medically Directed CRNA Rates

The medically directed CRNA conversion factors were set at 70% of the non-medically directed CRNA conversion factors. Therefore, they would begin in 1991 at \$10.50 and increase \$0.25 per year until they reached \$11.70 in 1996 (adjusted by geographic indices).

1991 -	\$10.50
1992 -	\$10.75
1993 -	\$11.00
1994 -	\$11.25
1995 -	\$11.50
1996 -	\$11.70

When the CRNA rates under OBRA90 were created, no one envisioned that anesthesiologist services would eventually be viewed as 29% overvalued under RBRVS. The fact that anesthesiologist services were ultimately viewed as 29% overvalued, versus 18% as originally projected, is the reason that anesthesiologist conversion factors have declined so dramatically in recent years.

The fact that anesthesiologist rates have declined, however, does not diminish the fact that the CRNA increases under Medicare are justified by the fact that they are not higher than they would have been if CRNA services were still paid for under the hospital reasonable cost pass-through. Any attempt to utilize a snapshot of CRNA Medicare conversion factors for 1990-1992 as a way of legitimizing future CRNA payment cuts is a misrepresentation of the history of CRNA payment under Medicare. The higher OBRA90 CRNA conversion factors merely brought equity to CRNA Medicare payment, which had been underpaid since 1989.

TABLE I. Simulation of Medicare Payments for Hernia Repair

Type of Practitioner and Supervision Ratio	1992 Payment	Cap at 100% of Solo Rate CRNA/Physician Split 50/50	Cap at 120% of Solo Rate CRNA/Physician Split 50/50
Payment per Case			
Solo Practitioner			
CRNA	\$169.10 [100%]	\$169.10	\$169.10
MD	\$169.10 [100%]	\$169.10	\$169.10
2:1 Team, Total	\$249.96 [133%]	\$169.10	\$202.92
CRNA	\$113.35	\$84.55 [-25%]	\$101.46 [-10%]
Physician	\$111.61	\$84.55 [-24%]	\$101.46 [-9%]
3:1 Team, Total	\$214.81 [127%]	\$169.10	\$202.92
CRNA	\$113.35	\$84.55 [-25%]	\$101.46 [-10%]
Physician	\$101.46	\$84.55 [-17%]	\$101.46 [0%]
4:1 Team, Total	\$204.66 [121%]	\$169.10	\$202.92
CRNA	\$113.35	\$84.55 [-25%]	\$101.46 [-10%]
Physician	\$91.31	\$84.55 [-7%]	\$101.46 [+11%]
Income per Hour		Income per Hour	
CRNA			
Solo	\$112.73	\$112.73	\$112.73
Medically Directed	\$ 75.57	\$ 56.37	\$ 67.64
Physician			
Solo	\$112.73	\$112.73	\$112.73
2:1	\$148.81	\$112.73	\$135.28
3:1	\$202.92	\$169.10	\$202.92
4:1	\$243.50	\$225.47	\$270.56

Simulation of Medicare payments for a hernia repair (4 relative value units (RVUs) and 6 time units) to anesthesia care team and selected divisions of payment between CRNAs and physicians [anesthesiologists]. Source: Rosenbach and Ammering 1993 for PPRC



American Payroll Association

New York Education Division

April 19, 1993

Mr. Mike Williams
Office of the Honorable Jim McDermott
1707 Longworth House Office Building
Washington, DC 20515-4707

Dear Mike,

Thank you for your time on the phone today. Attached is the American Payroll Association's position paper on the Health Care Financing Administration's (HCFA) a proposal to require employers to report employee health plan information on a new box on Form W-2, Wage and Tax Statement. The proposal is contained in Committee Report 103-8, pages 43-44, "Background Material on Federal Budget and the President's Proposals for Fiscal Year 1994."

As we discussed, we feel this is an ill-advised provision which should not be included in this package.

We understand that the attached will be part of the public record of the hearing. We would appreciate it if you could ask your Representative to raise these issues during testimony with any HGFA representative.

Thank you.

Sincerely,

Carolyn Kelley

Carolyn M. Kelley
Director, Government Affairs

cc: Mary B. Hevener, Lee, Toomey & Kent
Jim Medlock, CPP, Denver Water Department
Nora Daly, CPP, Pacific Bell

AMERICAN PAYROLL ASSOCIATION'S
POSITION PAPER ON
FORM W-2 REPORTING OF HEALTH INSURANCE

Proposal: The Health Care Financing Administration ("HCFA") has proposed to require employers to report in a new box on Form W-2 whether the employer has offered a group health plan (covering 20 or more employees) to the employee receiving the Form W-2, and whether the employee had elected single or family health coverage under such plan. HCFA hopes that Form W-2 reporting would facilitate enforcement of the "Medicare as Secondary Payer" ("MSP") rules that make Medicare the secondary, rather than the primary, insurer of active employees (or their spouses) who are age 65 or over, and of certain disabled employees (or disabled family members of current employees).

APA's Problems with HCFA's Form W-2 Reporting Proposal: The American Payroll Association opposes the requirement that health benefit information be reported on Form W-2, or collected by employers' payroll departments, for all of the reasons outlined below.

- (1) Health Plan Participation Data is Not Related to Other Form W-2 Data. This proposal would be the first expansion of employer reporting on the Form W-2 of elements which do not facilitate tax administration.
- (2) The Proposal Affects All W-2's, But Needed Data Concerns Tiny Percentage of Workforce. The proposed change adds unnecessary information to the Form W-2 for employees not affected by the MSP rules (i.e., where both employee and spouse are under 65 and not disabled). Employees affected by MSP rules are a very small percentage of the workforce.
- (3) The Proposal Imposes Undue Burdens on Payroll Departments. Many employers do not collect data about current health plan coverage in a system compatible with Form W-2 reporting, because:
 - (a) Normally, an employer's payroll system which produces Forms W-2 contains information relating to any health insurance deduction from the employee's pay. This deduction information and other payroll records usually do not include information HCFA wants about the health plan coverage that is offered to (and selected by) the employee;
 - (b) Many employers contract with a payroll service organization for the production and maintenance of the payroll records, including the production of the W-2. Payroll service organizations will not have access to the health insurance benefit

- 2 -

- (c) Health plan years often differ from calendar years, so the proposed Form W-2 entry providing health plan participation data could change during the year; and
 - (d) The employee's health plan election could change during the year, so the proposed Form W-2 entry would not cover the full year's data.
- (4) HCFA Needs Information Not Collected by Proposal. The proposed Form W-2 reporting will not provide HCFA with all the information required to enforce the MSP rules. Because the Form W-2 will never (and cannot) provide names, ages, EINs, or disability status of dependents, HCFA's costs of enforcing the MSP rules may not be decreased at all by the proposed change.
- (5) Form W-2 Health Plan Data Won't Prove an MSP Violation. The information required by HCFA's proposal will not necessarily prove that the MSP rules have been violated. The mere existence of a Form W-2 showing participation in a "group health plan" does not mean that the recipient (and his spouse or any disabled family member) must be covered by Medicare on only a secondary basis. For example, retired employees covered by retiree health plans (that can legitimately be secondary to Medicare) often receive payments from former employers. Also, disabled employees (or disabled family members of employees) in small group health plans are not subject to the MSP rules (which apply only to group health plans covering 100+ workers). In both of the above cases, HCFA may wrongly presume that there is a violation of the MSP rules, without investigating the employer to obtain more information.
- (6) Many MSP Violations Will Not be Detected by Proposal. The information provided will not indicate all cases where MSP rules may have been violated, because it provides no information on certain persons (such as independent contractors) who can be treated as "active individuals" for whom Medicare should be secondary.

Summary: In summary, this proposal provides HCFA data it does not need, and HCFA will still need data it cannot get off the Form W-2. HCFA's administrative costs will not decrease significantly, but employers' administrative costs of collecting and maintaining this data will increase unnecessarily. HCFA should abandon this proposal and instead consider less far-reaching information reporting changes to help administer the MSP rules. HCFA's reporting needs can be provided from employers to HCFA in a more efficient manner, which does not involve the Form W-2 or any other wage statement information return or data base maintained by a payroll department.

**TESTIMONY OF THOMAS A. BONFIGLIO, M.D.
AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS**

Mr. Chairman, I am Thomas A. Bonfiglio, M.D., president of the American Society of Clinical Pathologists. Although your hearing today focuses on budget issues relating to payment under Part B of the Medicare program for clinical laboratory services, the inclusion of two cost -saving measures -- direct billing and a physician self referral prohibition -- both currently included within the Medicare program, would be ideal components of the overall private sector reform of our nation's health care system. On behalf of ASCP, I am pleased to offer encouragement and support for the inclusion of these two measures within a Congressionally passed health reform package.

The American Society of Clinical Pathologists (ASCP) is a nonprofit medical specialty society organized for education and scientific purposes. Its membership numbers more than 66,000 board certified pathologists, other physicians, clinical scientists and certified medical technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel.

ASCP recognizes the importance of reforming our nations health care system, insuring patient safety and containing the skyrocketing costs of medical care. The practice of "marking up" or adding charges to the usual and customary fees billed to patients, substantially increases the cost of laboratory services without providing any additional medical benefit. According to a recent study by the Center for Health Policy Studies, a national direct billing law would save between \$2.4 and \$3.2 billion dollars a year.

Quality health care depends largely upon the availability of reliable information derived from diagnostic or screening procedures, such as that provided by laboratory tests. Yet, despite the enactment last year of stringent quality control standards for clinical diagnostic laboratories, questionable financial incentives which influence selection of a laboratory and of laboratory tests continue to undermine the quality of health care. Fundamental changes in the delivery of laboratory services are necessary. If laboratory reform efforts, begun with the passage of The Clinical Laboratory Improvement Amendments of 1988, are to truly result in better patient care and more reasonable consumer costs, we believe that enactment of a direct billing requirement is essential.

What Is Direct Billing? Direct billing means that laboratories request payment directly from either the patient or a financially responsible third party (e.g. an insurer) rather than the physician requesting the test(s).

Why Is Direct Billing Necessary? The billing of physicians rather than patients promotes the practice of mark-up by the physician, resulting in cost to the patient or third party payor which may be excessive and disproportionate to actual administrative expense or to any added value provided by a physician's interpretation of test results. In a survey of 1200 primary care physicians practicing across the United States, the average mark-up on tests performed by reference laboratories was 139 percent, as reported by Market Fact, Inc., in June 1988. The report further stated that 16 percent of those surveyed charged patients more than three times the price billed by the laboratory.

When physicians have the opportunity to incur such financial gains, the selection of the laboratory, the number of tests requested, and the types of tests requested may well be influenced by the potential for pecuniary benefits. The American Medical Association's Current Opinions of the Council on Ethical and Judicial Affairs (1986; Section 6.08) encourages direct billing, and Section 8.08 strongly discourages physician mark-up of laboratory services by recognizing that "the physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides him with low cost laboratory services on which he charges the patient a profit, is not acting in the best interests of his patient."

Is Direct Billing Fair To Physicians? Yes. Eliminating the physician as middleman in the billing process will not preclude the physician from charging for his or her legitimate interpretation of laboratory test results. Physicians will, however, be more accountable to their patients for such charges, since they will no longer be disguised in the test mark-up. This is an important consumer protection feature of direct billing.

Can Direct Billing Affect Quality Assurances? Yes. Enactment of the Clinical Laboratory Improvement Amendments of 1988

directed attention to the importance of quality assurance in the laboratory. Quality assurance programs require time, effort, and expense. A laboratory that offers services at unreasonably low costs may be incapable of adhering to recommended procedures intended to insure the best possible clinical results.

This is particularly true for cytology screening services. Inadequacies of Pap smear screening have been the focus of public concern. The problem stems from incorrect evaluations performed in laboratories in which there was inadequate attention devoted to quality assurance. This screening test is offered at unrealistically low cost as an inducement to physicians to select that laboratory.

Is Direct Billing Feasible? Yes. New York and Rhode Island have enacted a direct billing law. The Deficit Reduction Act of 1984 requires that laboratories bill the Medicare Program directly for services provided to Program beneficiaries. In addition, many states require similar billing procedures for patients enrolled in Medicaid Programs

Is Truth-In-Billing (Disclosure) A Reasonable Alternative To Direct Billing? No. Although some state laws require that the physician's bill to the patient disclose the actual laboratory charge, this approach has proven to be ineffective and virtually unenforceable. In 1980, Congress adopted a disclosure requirement and a provision limiting the amount of the physician's mark-up to a "nominal fee" to defray the costs of specimen collection and handling for Medicare beneficiaries. In 1984, apparently finding that this provision did not protect the patient or the Program, Congress rejected disclosure requirements and now requires direct billing. All patients deserve the same type of protection.

Will Direct Billing Result in Lower Patient Prices? Yes. We believe that elimination of the physician mark-up will result in lower prices to patients and third-party payors because financial gain will no longer provide the motivation for physicians to order unnecessary or more expensive tests. In New York, where direct billing for non-Medicare laboratory services has been in effect since 1970, Medicare prices (determined on the basis of non-Medicare patient and third-party payor prices) are lower than in any other comparable

industrial state and are 17 percent below the national average. We believe these cost savings are attributable to direct billing.

At the very least, direct billing will assure that the entire payment for laboratory services is received by the facility actually rendering service. Appropriate compensation to laboratories will permit them to comply with the enhanced quality control requirements enacted into law last year.

Direct billing, by removing the referring physician's potential for financial gain in the selection of laboratory and test(s), will result in improved health care. Tests, ordered solely on the basis of medical necessity, will be provided by laboratories selected on the basis of performance rather than on the physician's realization of increased revenue. The ultimate beneficiary of this requirement is the patient. Therefore, we urge your support of a national direct billing law.

Once again, thank you for your efforts to improve our nation's ailing health care system. I hope you and your staff will contact ASCP for any assistance that we can provide to you. If you have any questions or comments, please do not hesitate to contact either John H. Madigan Jr. or Alan Morgan in our Washington Office at 202-347-4450.

TESTIMONY OF AMERICAN SOCIETY OF INTERNAL MEDICINE

The American Society of Internal Medicine (ASIM) is pleased to present the following testimony for the record of the Ways and Means Subcommittee on Health on budget issues relating to clinical laboratory services and physician ownership and referral arrangements. ASIM represents 26,000 internists nationwide who provide primary and subspecialty care to Medicare patients.

Laboratory Fee Schedule Reductions

The proposed cuts in the Medicare laboratory fee schedule are of concern to internists, many of whom are struggling to keep their office laboratories open at a time when their costs are increasing due to the requirements of the Clinical Laboratory Improvements Act (CLIA). We believe that the administration and Congress should reassess the impact of those cuts on the ability of primary care physicians to provide their patients with quality laboratory testing. If it turns out that many physicians are in fact being forced to close their laboratories due to the high costs of complying with CLIA and lower Medicare payments, Congress should consider modifying the administration's proposal to allow for payments that are sufficient to cover the costs that physicians incur in providing their Medicare patients with the convenience of an in-office lab. To allow for Congress to make an informed judgement, ASIM recommends that Congress require HHS to study and report annually to Congress on changes in the number of labs operated by physicians and the impact on beneficiary access to those services, including an assessment of the impact of costs of complying with CLIA and reduced laboratory reimbursement on availability of in-office laboratory testing.

Exemption for "Shared" Office Labs

The administration also proposes to extend the ban on physician "self-referrals" to facilities other than clinical laboratories. ASIM supports further restrictions on potentially abusive self-referrals, provided that "shared" laboratories (and certain services that are an intrinsic part of physicians' practices, as discussed later in our statement) are exempted. Such an exemption was contained last year in H.R. 11, which was vetoed by President Bush, and has been re-introduced as part of H.R. 21, introduced by Rep. Dan Rostenkowski (D-IL). It is essential that Congress promptly enact the shared laboratory provision in H.R. 21 so physicians who are in shared office laboratory arrangements can continue to deliver the same high-quality clinical laboratory testing services to their Medicare patients that they have in the past.

Shared laboratories are office laboratories that are shared by several physicians to provide testing for their own respective patients, usually located in space contiguous to their offices, but which do not otherwise meet the definition of a group practice. These are common business arrangements, particularly in primary care settings, and are often the only way many physicians can afford to maintain a lab for their patients. If a shared laboratory exemption is not enacted, a large number of physicians will be forced to shut down their in-office laboratories and to send their Medicare patients to outside facilities—costing the patient added time, effort and expense—to obtain the same services.

Clinical laboratories owned by solo physicians and group practices are exempt from the Stark ban on physician self-referral. We firmly believe that a conflict of interest is no more inherent in a limited shared laboratory arrangement than in a group or solo practice that provides laboratory services to patients. Shared clinical laboratory arrangements are a convenient and cost-effective way to provide quality patient testing in an office. In this time of rising health care costs, it makes no sense to prohibit this practical and economical way of providing laboratory services to Medicare patients.

Physicians have been waiting for over three years for guidance from HHS or Congress regarding shared facilities, and none has been provided. Even now, physicians have no way of knowing whether they must restructure their arrangements or whether they will be required to refund payments received since January 1, 1992, the effective date of the law. As a result, many physicians are being forced to form group practices solely for the purpose of providing patient testing, so as to avoid any potential risk associated with the Stark prohibition. For many internists, however, the formation of a group practice for the sole purpose of providing patients with laboratory services is simply not feasible. Therefore, many more have closed—or may soon be forced to close—their laboratories. The uncertainty and frustration experienced by physicians about this issue has been compounded by the Department's decision to require shared facilities to pay for separate CLIA certificates (as well as fees, inspections and proficiency testing) for each physician in a shared arrangement.

Recently, a coalition of physician organizations sent a joint letter supporting the shared laboratory exemption in H.R. 21 and urging Congress to resolve the shared laboratory problem at the earliest opportunity this year. This coalition includes the American Medical Association, American Academy of Family Physicians, American Society of Internal Medicine, American College of Physicians, American Association of Clinical Endocrinologists, American College of Rheumatology,

American Society of Hematology, American Society of Clinical Oncology, American Academy of Dermatology, American College of Obstetricians and Gynecologists, and the Joint Council of Allergy and Immunology.

The absence of a shared laboratory exemption to the self-referral ban presents an enormous problem that is already having a negative impact on physicians' ability to provide medically necessary laboratory tests for their patients. We urge Congress to enact the shared laboratory provision in H.R. 21, modified to eliminate the grandfather clause that limits the exemption only to those laboratories in existence prior to June 26, 1992.

Exemptions for In-office Ancillary Services

New self-referral legislation should also continue the current exceptions to the general ban on referrals in the current law for in-office ancillary services. Specifically, ASIM believes such services should include laboratory, x-ray, EKG, ambulatory surgery centers, renal dialysis facilities, holter monitor studies, flexible fiberoptic sigmoidoscopy, stress tests, sonography, ENDO-thyroid scans, Doppler Vascular studies, oxygen saturation studies, chemotherapy, pulmonary function, and IV infusions. These ancillary services are integral and critical to the practice of internal medicine.

ASIM is particularly concerned about maintaining the exception for in-office diagnostic radiology. The Society is aware that the American College of Radiology is urging Congress to expand the self-referral ban to x-ray and other radiology services provided by nonradiologists, arguing that this could be a possible source of Medicare savings. ASIM strongly believes that restrictive limitations on in-office diagnostic radiology are not in the best interest of patients. Such a policy would neither save funds nor improve patient care. Instead, it would seriously inconvenience patients, delay diagnosis and treatment, and increase the cost of care. To illustrate, if an elderly patient goes to an internist's office complaining of a cough and fever, the internist will perform a history and physical examination on the patient. The physician may order a chest x-ray if he or she determines one is necessary to diagnose whether the patient has pneumonia. If the physician has the x-ray done in-office, he or she is able to diagnose and treat the patient immediately. However, if the physician is unable to perform in-office diagnostic radiology, the patient would have to go to another office or hospital to have the x-ray taken and return for treatment. Not only does this inconvenience the patient, but the cost of the care received may be higher as a result.

ASIM strongly believes that no one specialty has the exclusive "right" to perform imaging services. These diagnostic procedures are an integral part of patient care in many specialties. In the interest of timely and quality patient care, we believe that all physicians should be allowed to perform in-office diagnostic radiology as long as they have the appropriate training, experience and demonstrated competence. We urge the subcommittee to continue to protect patients' access to convenient and cost-effective in-office radiology procedures when considering new self-referral legislation.

Finally, ASIM urges the subcommittee to continue to protect physician ownership in and referral to renal dialysis facilities from any new bans on self-referral. There are special circumstances that require that "referrals" to renal dialysis facilities be protected from legislation prohibiting the practice of self-referrals. Unlike most other "referral" facilities, dialysis provides a medically necessary therapeutic service. Because of this, such services are often an extension of the physician's practice. For this reason, ASIM strongly believes that referrals to dialysis centers by a physician, even if the physician has an ownership interest in the center, should not be prohibited.

Thank you for the opportunity to submit comments on 1994 Medicare budget issues relating to clinical laboratory services and physician ownership and referral arrangements. ASIM looks forward to working with Congress on these and other health care issues in the future.

THE COUNCIL OF NURSING HOME SUPPLIERS
WRITTEN TESTIMONY
PRESENTED TO THE WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
ON THE
ADMINISTRATION'S FY 1994 MEDICARE BUDGET
APRIL 20, 1993

Mr. Chairman and members of the Subcommittee, my name is Neal Thrift. I am Vice President of Care Supply, Inc., a nursing home supply company, and I am also Chairman of the Council of Nursing Home Suppliers ("CNHS"). I am pleased to have the opportunity to present written testimony, on behalf of the Council of Nursing Home Suppliers, regarding the Administration's FY 1994 Medicare budget.

CNHS members provide medical supplies and services to more than 100,000 nursing home residents in more than 40 states. The Council members furnish prosthetic devices -- which are devices which replace all or part of an internal body organ -- prosthetics and orthotics, surgical dressings, and splints and casts. Many of the products and services that CNHS members supply are covered under the Medicare Part B program. All these products are furnished to nursing home residents pursuant to physician certification of medical necessity. Many of the products are highly specialized, used by only 2 to 15% of each facility's residents, and often requiring the facility's nursing personnel to have specialized knowledge and training to apply and use the products properly.

Health care coverage and costs have been the focus of intense debate and study for the new Administration. On March 31, 1993, Acting HCFA Administrator, William Toby, outlined the Administration's Medicare proposals which it believes will help curtail the enormous federal expenditures for health care costs and at the same time reduce the federal deficit. While the Council supports most of the ideas of the Administration, we do have some serious concerns.

- I. Elimination or Reduction of Presently Covered Medicare Benefits for Nursing Home Residents by Reclassifying Orthotics and Prosthetics and Parenteral and Enteral Nutrition (PEN) as Durable Medical Equipment (DME) under the Medicare Program.

Our main concern with the Administration's proposal is that it will eliminate Medicare benefits currently provided to nursing home residents by redefining orthotics and prosthetics, as well as parenteral and enteral nutrition, as DME under the Medicare program. Although the majority of nursing home patients are covered by Medicaid or private insurance, many are also eligible for Medicare Part B coverage. Currently, Medicare Part B pays for orthotics and prosthetics and parenteral and enteral nutrition when they are provided to patients in nursing homes. In contrast, Part B will not cover durable medical equipment supplied to nursing home residents because the nursing home does not qualify as the patient's "home" under current Medicare law. Therefore, if orthotics, prosthetics and PEN are "lumped" into the definition of DME, they would no longer be covered or reimbursed by Medicare Part B for residents of nursing homes. Hence, under the Administration's proposal, these important benefits will be reduced or eliminated under Part B and this poses difficulties for beneficiaries, nursing homes and suppliers.

For private-pay nursing home residents, the elimination of Medicare Part B coverage for these products means that the cost of these products would fall on the patient or the patient's family directly. Residents are already paying large sums of money for the care they receive at nursing homes and it will be difficult for them to absorb the additional cost of these supplies. In the longer view, these added costs would extinguish

the patient's assets sooner, making the patient eligible for Medicaid, and thus increasing the cost to the Medicaid system.

For Medicaid-eligible nursing home residents, if these products are not paid by Medicare Part B, they will likely have to be paid by the nursing facilities as part of their "routine costs." The financial impact on nursing facilities' current payment rates would be significant and costly, especially for the patients who require parenteral or enteral nutrition therapy. Many of the sicker patients may stay longer in acute care hospitals and not be admitted to nursing facilities, which are not considered the patient's home for purposes of providing DME. This could cause the Medicare system to pay significantly more money should hospital stays lengthen. If the Administration's proposal to include orthotics and prosthetics in the definition of DME is implemented, it may decrease incentives for nursing facilities to take these acute or skilled patients.

Folding enteral and parenteral nutrition into DME presents special concerns. Currently, supplier services covered by Medicare Part B when rendered to nursing home residents include clinical nutritional assessment, timely emergency delivery and allocation, accurate and sophisticated billing mechanisms (generally electronic services), and patient training programs. These services would be eliminated -- or nursing facilities would have to assume them -- if reimbursement for enteral therapy is discontinued under Medicare Part B for patients residing in skilled nursing facilities.

II. Electronic Billing

The Council of Nursing Home Suppliers applauds and supports the Administration's proposal to adopt an incentive for electronic billing. The Council believes, however, that any charge for submission of paper claims should be waived when a supplier is either requested or required by a Medicare carrier to submit or resubmit its claims in paper form.

III. Prior Authorization of "Overused" Items.

The Council believes that the Administration's proposal to require that the medical need of overused items be demonstrated in advance of delivery to patients should not apply to orthotics and prosthetics (including prosthetic devices and parenteral and enteral nutrition). These products are disposable, generally sterile, supplies which are provided to patients who have one or more organs or bodily part which has ceased to function. If a patient does not receive a prosthetic device in a timely manner, he or she could suffer increased medical complications.

For example, patients frequently remove their own catheters, which are a prosthetic device used to drain the bladder. A patient needing an additional catheter cannot wait to have his bladder drained until the Medicare carrier approves an exception to its "two per patient per month" utilization screen. Similarly, if a Doctor prescribes 2400 calories of nutrient per day for an enteral therapy patient, the patient should not be forced to wait until the doctor can "demonstrate the medical necessity" of 2400 calories rather than the 2000 calories that the Medicare carrier normally allows. A patient in need of many orthotics and prosthetics may be unable to wait for physician clarification before receiving a product which could be necessary for survival, such as nutrients, or basic hygiene.

IV. Recommendations

The Council of Nursing Home Suppliers has always advocated a "level playing field" for both Medicare beneficiaries and suppliers. To achieve this end, the Council believes that the Adminis-

tration should implement three things: (1) national uniform coverage guidelines, (2) national uniform utilization screens, and (3) national uniform reimbursement rates for prosthetics and orthotics. This would provide a higher quality of medical care, discourage abusive practices and provide the beneficiary and providers with a greater degree of certainty while saving money.

Mandating national reimbursement rates for prosthetic devices is consistent with the Congress's earlier mandates for national fee screens for parenteral and enteral nutrition (PEN) supplies, and "national" payment rates with regional variations for durable medical equipment (DME). Since CNHS members market nationally, CNHS members favor the adoption of national fee screens, similar to PEN reimbursement, rather than the DME model which permits regional variations in payment.

The Council of Nursing Home Suppliers, as previously stated, supports the Administration's proposal to implement electronic billing incentives, which the Council believes will significantly reduce Medicare's administrative expenditures.

V. Conclusion

The Council of Nursing Home Suppliers generally agrees with the Administration's proposal but believes that the DME portion is too vague and needs to be supplemented.

Mr. Chairman and members of the Subcommittee, we thank you for the opportunity to present our views. We are always willing to be of help to you and your staff.

This concludes my statement. I will be happy to answer any questions that you or members of your Subcommittee may have.

STATEMENT

NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE

The National Association for the Support of Long Term Care is a broad based alliance of suppliers and providers of professional medical services and products meeting the needs of nursing facility residents. Over 150 companies are active NASL members. Through our structure of six working coalitions (rehabilitation, wound care, medical product and supplies, portable X-ray, clinical laboratory, and pharmacy services), we are able to provide an assessment of issues which would affect the ancillary and support services offered in the nursing facility setting.

We appreciate this opportunity to (i) comment on the impact of President's proposed reductions in Medicare and Medicaid, (ii) evaluate alternative approaches and (iii) suggest several technical amendments which would improve the efficiency and responsiveness of these public programs for beneficiaries. Our comments on the proposed changes are best evaluated in the context of the evolving role of the nursing home industry in the delivery of health services. Allow us to first review these changes.

I. Transformation of the Nursing Facility Industry:

Members of this Committee should feel proud that they have had a significant role in molding the dramatic transformation which is occurring within the nursing home industry. Nursing homes are becoming the center for post acute medicare services.

Three dynamics have propelled this transformation:

- higher patient acuity: Nursing facilities have stepped up to meet the service gaps caused by hospitals discharging patients "quicker and sicker."
- changing payer mix: "Mainstreaming" has opened additional payer sources for nursing facilities and enhanced opportunities to compete on market differentiations of quality and program.
- regulatory mandates: The nursing home reform amendments codified in OBRA 87 require that facilities assume legal responsibility for helping residents achieve "the highest practicable level of functioning."

The continuing evolution caused by these three factors, (i) need (utilization), (ii) market opportunity (reimbursement), and (iii) mandated changes (regulations) have placed tremendous demands on facilities to upgrade medical professional services. Nursing facilities have strengthened physician relationships, increased the utilization of specialty medical services and supplies and expanded specialty programs. They have turned to the members of NASL soliciting an expansion of our support services and programs to meet their residents needs.

II. Evaluation of the President's Proposals.

In his "Vision of Change for America" address, President Clinton made a compelling argument for his economic plan of revenue enhancements, targeted cost containment and stimuli investments. While we have made no attempt to achieve a consensus view on the specifics of the package, members of the National Association for the Support of Long Term Care, as do most Americans, share the vision of a strong, vibrant economy.

We have focused our review on the specifics of the proposed \$62.3 billion in proposed Medicare and Medicaid program reductions using three broad criteria:

- evaluation of changes on services to beneficiaries,
- evaluation of changes on the evolving care structure, and,
- evaluation of incidence and impact upon providers.

Proposed changes should not curtail services to those most in need. The 35.6 m elderly and disabled Americans who rely on Medicare as their primary health insurance are as dissimilar as they are similar, i.e., they reflect the population at large. Medical need, social support, living arrangement, and economic ability to absorb health care costs differ. While few generalizations can be made, two are substantiated by demographic data: (i) older beneficiaries have the greatest medical and economic support needs, and (ii) older beneficiaries are high users of health care services. Proposed changes should not restrict responsive care delivery. As suggested above, our care delivery system has been evolving to respond to these changes in beneficiary needs. Nursing homes, home care and related community based out-patient delivery systems have emerged as the responsible provider for post-acute treatments. Proposed changes should be fair to providers. Medicare and Medicaid must have the capacity to deliver promised coverage.

Applying these criteria to the proposed Medicare and Medicaid programs reductions, NASL offers the following observations:

- Many of the proposed changes are reductions at the margin which can be absorbed with limited impact on beneficiary service or delivery capability. It appears as if a realistic effort has been made by the Administration to target program reductions in a manner which reflects the changing pattern of service demands from the acute hospital toward outpatient and post-acute services.
- The proposed reductions in DMEPOS are a potential problem for both beneficiaries and suppliers. During the past six years, the Congress and the Health Care Financing Administration have focused on a few highly publicized program abuses to generate repeated changes in both statute and regulations. Absent a settling of requirements, it is difficult to know whether beneficiary access to services have been restricted or whether supplier delivery capacity has been impaired. Proposed DMEPOS containment initiatives savings should conform to the projected savings from the reforms incorporated in H.R. 21, and Congress should move to expeditiously consider this reform package.
- The proposed reductions in clinical laboratory services will have a tremendously disruptive effect on the availability and appropriateness of such services for beneficiaries residing in a nursing facility. While linkage to market pricing might be appropriate for the high volume, narrow product laboratories that market to outpatient clinics and physician offices, such economies of scale and product restriction are not available to the small community labs which support skilled nursing facilities. Congress has recognized the uniqueness of these services in enactments which address trip and draw fees, and, NASL believes it is appropriate for the Congress to differentiate in fee scheduling between services provided in the nursing home setting and those provided to the general population. Such a differentiation would encourage facilities to strengthen their medical programming to support patients with higher acutities knowing that their small community labs will be able to provide necessary service supports. This carve out approach preserves most of the projected savings and assures OBRA and CLEA compliance by nursing facilities serving

the high risk, often non-ambulatory beneficiary. Attached is a set of suggestions coming from some of our members which might merit consideration by the committee (See Appendix A).

- A similar concern needs to be expressed related to the proposed concept of bundling radiology services. Increased patient acuity and greater medical direction has increased the demand for portable x-ray and specialized radiology services in the skilled nursing setting. Most nursing facilities make provision for the delivery of these highly specialized services. While we are not in a position to evaluate the merits of the proposed approach for hospital services, we believe there is a continuing necessity for direct bill capability for services to the nursing facility setting. Changes which might affect services in skilled nursing facilities must be carefully studied.
- The proposed change to eliminate the return on equity for skilled nursing facilities will have a negative impact upon providers. It is the wrong time to take away this capital incentive for skilled nursing providers. OBRA 87 and subsequent reforms initiatives at the state level have placed great demands on service providers. To remove the return on equity incentive at the same time that public policy is requiring additional plant investments would be to thwart the infusion of necessary capital.
- We support the proposals to tightening estate and asset rules under Medicaid. NASL supports the Partnership for Long Term Care initiative launched by the Robert Wood Johnson Foundation and believes this concept will help deterring unwarranted asset transfers.

III. Evaluation of Alternative Approaches:

It has come to our attention that several alternative ideas have been advanced to achieve similar or more cost savings than those proposed by the President.

Media reports have indicated that the President may propose and the Congress may consider government price controls on the health sector. As others have testified to the Committee, price controls are ineffective and distort both the quality of service and the efficiency of its delivery. NASL firmly opposes price controls. We hear the idea of an across-the-board Medicare freeze has been advanced. Such an approach rewards the haves and penalizes the have-nots. It fails to recognize the changing patterns of expenditures from the acute to the post-acute setting; it works to the disadvantage of emerging health sectors; and it undermines their responsiveness to beneficiaries. NASL strongly opposes an across the board freeze as an alternative to targeted reductions. Finally, we hear a number of ideas have been suggested to increase beneficiary co-payments and deductibles as a means of cost containment and volume control. Suggestions have included ideas for increasing the age of eligibility for Medicare. We believe these systems reforms are best debated as part of the anticipated sweeping health care reforms proposals which will be before the Congress later this year.

IV. Ideas for Improving Efficiencies and Responsiveness:

The focus of this hearing is on measures which would improve the efficiency and effectiveness of the Medicare and Medicaid programs. Toward that end, we firmly believe that enhancing the service capabilities of the nursing home industry will generate both savings and quality improvements. Moving to improve

professional medical services in the nursing home sector, we believe the committee should consider, at a minimum, the following ideas:

- DMEPOS/HR 21: Enact the provisions of H.R. 21 providing statutory direction to the HCFA initiative on DMEPOS and addressing specific concerns raised by beneficiaries and providers assuring uniformity of coverage, reimbursement and due process.
- Salary Equivalency: Direct the Secretary of HHS to rebase the outdated salary equivalency standard imposed on contract suppliers of physical therapy and respiratory therapy. The rate methodology is based on a formula established over 20 years ago. Current limits were last reviewed by HCFA over a decade ago.
- Wound Care: Clarify the coverage of wound care supplies under Medicare Part B by changing the wording of Section 1861 (s) (5) of the Social Security Act which references "surgical" dressings to "wound" dressing.
- Access to the Common Working File: Provide limited access to the common working file for supplies for the sole purpose of determining beneficiary eligibility under the Medicare program. At present suppliers are required to provide service without assurances of beneficiary status.
- Prohibit Retroactive Rulemaking: Any significant change governing Medicare policies, i.e., coverage, utilization, and/or reimbursement, should require a minimum 30 day notice to suppliers, providers with the effective date of any such change to be implemented on the basis of dates of service to beneficiaries.
- Regulatory Assessment: Direct the Secretary to provide separate assessment of rules on beneficiaries residing in nursing facilities. Given the importance attached by the Congress to the OBRA 87 nursing home reforms, it would be a significant reinforcement of Congressional intent if proposed rules were evaluated not only on their general impact on health services, but also their specific impact upon beneficiaries who reside in nursing facilities.
- Respiratory Therapy in the SNF Setting: Current statute mandates skilled nursing facilities to contract with a hospital with which the facility has a patient transfer agreement to receive respiratory services. This gives the hospital a virtual monopoly on services dictating both price and level of service. Such an approach is both inefficient and ineffective. Respiratory therapy should be a covered service in the SNF setting same as other rehabilitation services.
- Prescription Drug Benefits: Coverage for prescription drugs and related pharmacy services should be better coordinated between the Medicare and Medicaid programs to ensure that cost-effective therapy is available to patients in nursing facilities.

V. Conclusions:

Members of the National Association for the Support of Long Term Care (NASL) appreciate this opportunity to share our views. As we emphasized throughout this testimony, strengthening the delivery capabilities of nursing facilities offer the most cost effective and efficient means of delivering post-acute professional medical services.

442

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We look forward to working with members of the Committee and their staffs in drafting an enactment responsive to beneficiary needs and economic realities.



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